

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO.		9. 21038					
1. DECEASED NAME (TYPE OR PRINT) BENJAMIN CHARLES ADKINS				2a. DATE OF DEATH Aug. 24, 1979		2b. HOUR 2:15 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 6 10 15		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wicomico Co		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dykes Rd. Rt # 9		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) florist		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Wicomico 13c. CITY OR TOWN Salisbury				14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15. STREET ADDRESS Dykes Rd Rt # 9			
14. FATHER'S NAME John W. Adkins				15. MOTHER'S MAIDEN NAME Bertha Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 217-30-7945		17. INFORMANT EMMA LEE ADKINS SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer 1629 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 8/24 1979 to 8/24 1979, that (I) (we) lost the deceased alive on 8/24/79 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph A. Grasso				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso				22e. ADDRESS Peninsula Gen. Hosp. Salisbury Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/27/1979		23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Md			
24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds				ADDRESS Salisbury Md		25a. DATE REC'D. BY REGISTRAR AUG 28 1979		25b. REGISTRAR'S SIGNATURE Anthony McBrady	

BP

8612 12



12/12/12

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

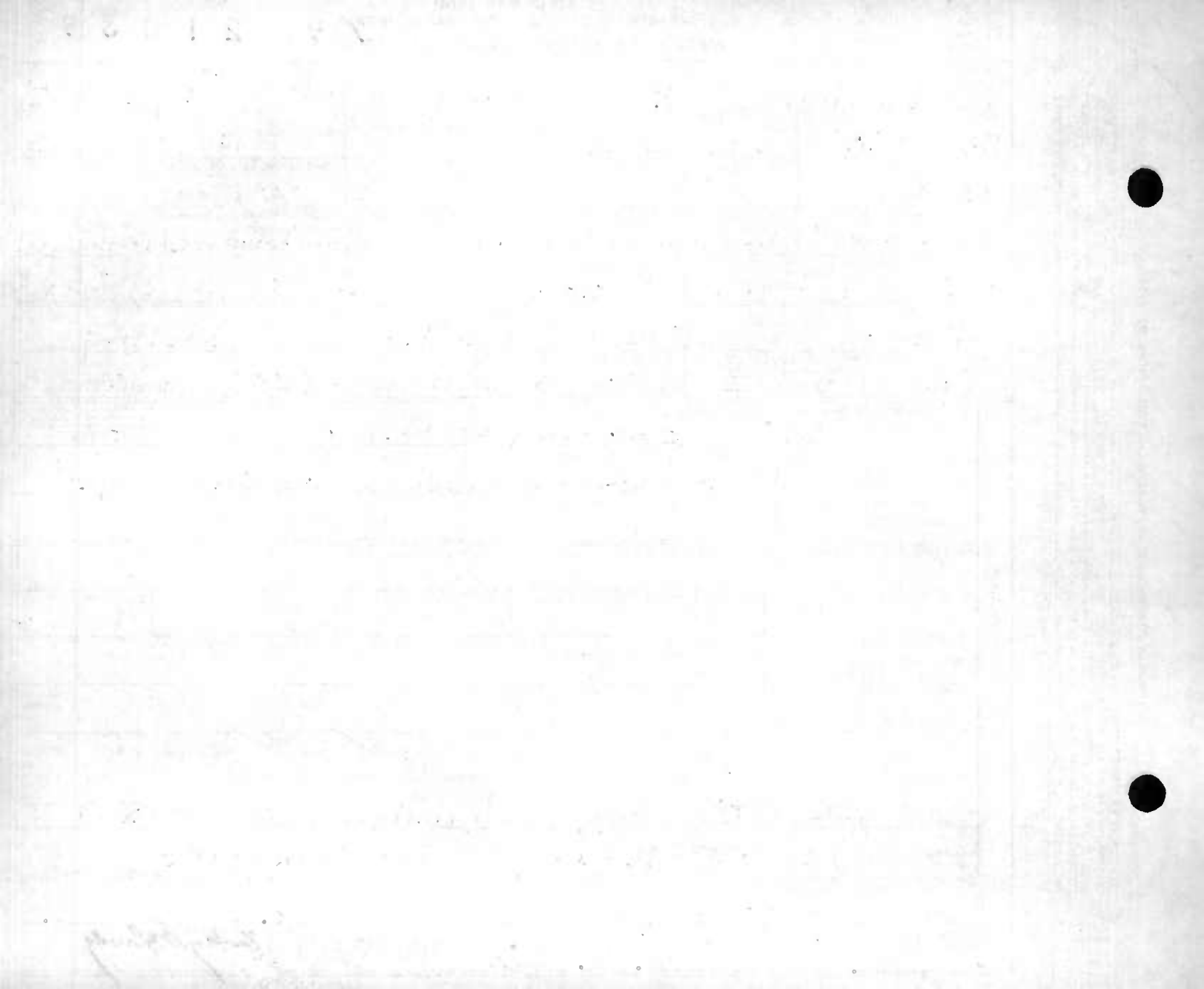
BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21039

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21039	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR	
William		H		Airey, Sr		Aug 18, 1979				12:00 AM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	W	3 12 22		57 YRS.						Aug 18, 1979		12:00 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore		USA		WIDOWED		DIVORCED		Wicomico		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING-LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury		Peninsula General		Maintenance		Beth Steel							
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
Md		Baltimore		Glen Arm		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 2 Box 539-25 Glen Arm					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Albert		Airey		Sally		Stalling							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WW II		215-16-1760		Nellie Airey (wife) same address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a)												min	
410- coronary occlusion													
DUE TO, OR AS A CONSEQUENCE OF													
(b) hypertensive cardiovascular disease												yrs	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION		CITY OR TOWN		COUNTY STATE	
								STREET					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
John G Bulkeley				Deputy				8-18-79					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
John T Bulkeley				Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial				8/21/79		Loudon Park				Balto.		Md.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Schimunek Funeral Home, Inc.				9705 Belair Rd. Balto. Md. 21236				AUG 21 1979		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 1 0 4 0

1 - FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE AUGUSTA Ard's		2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR August 10, 1979 540 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 18, 1894	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	6b. CITIZEN OF WHAT COUNTRY? USA	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Shirt Mfg.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Wicomico Salisbury		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13c. STREET ADDRESS 314 Charles St.		14. FATHER'S NAME FIRST MIDDLE LAST John Williams	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Hillman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 214-10-6986		17. INFORMANT (son) ADDRESS Mr. J. William Phipps, Salisbury, Md. 220 Chestnut Way	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 410- IMMEDIATE CAUSE (a) Acute Inferior Wall Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe Coronary Artery Stenosis			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/7, 1979, to 8/10, 1979, that (I) (we) lost saw the deceased alive on 8/10, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Benito S. Chan MD		22c. DATE SIGNED 8/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENITO S. CHAN		22e. ADDRESS 547-D Riverside Drive Salisbury	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/14/79	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland	
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	

BP

0 0 0 1 2 3 4 5 6 7 8 9

THE UNIVERSITY OF  
CHICAGO  
LIBRARY

Aug 10 1942

Chicago

Peninsula General Hospital

Salisbury

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

21041

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES HENRY Baker</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 18, 1979</b>			2b. HOUR <b>5:45</b> M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 27 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DELAWARE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HIGH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hsp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farmen</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Pittsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>Box 180</b>								
14. FATHER'S NAME <b>Louder</b>				15. MOTHER'S MAIDEN NAME <b>Hettie Moore</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>222-10-0457A</b>		17. INFORMANT ADDRESS <b>Mrs Oscar White Pittsville, Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Congestive Heart Failure, Cardiogenic shock</b> (c) <b>Atherosclerotic coronary artery disease</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>chronic obstructive pulm. disease, Diabetes mellitus</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>8:15</b> 19 <b>79</b> to <b>8:18</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>8:12</b> 19 <b>79</b> <b>8:45 PM</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Saggar</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/18/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. SAGGAR</b>		22e. ADDRESS <b>547 Riverside Drive suite E Salisbury</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8/21/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pittsville Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pittsville Wic. Md</b>		
24. FUNERAL DIRECTOR NAME <b>Hill-Baker-Bounds</b>		ADDRESS <b>Salisbury, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 24 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <i>Hortence Leatherbury Barkley</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>August 2 1979</i> 2b. HOUR <i>2:45 PM</i>		
3 SEX <i>Female</i>	4 RACE <i>NEGRO</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>6 11 16</i>	6 AGE (YEARS LAST BIRTHDAY) <i>63</i> YRS MONTHS DAYS HOURS MIN.		IF UNDER 1 YEAR IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Mr. Vernon, Md.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD.		
10 CITY OR TOWN OF DEATH <i>Salisbury</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>		12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Md.</i> 13b. COUNTY <i>Wicomico</i> 13c. CITY OR TOWN <i>Salisbury</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	14. STREET ADDRESS <i>Rt. 756 SALIS. Schumaker Drive Md.</i>			
14 FATHER'S NAME FIRST MIDDLE LAST	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sadie Leatherbury</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> 16b. SOCIAL SECURITY NO.		
17 INFORMANT ADDRESS <i>James A. Barkley same as above</i>			18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 2500 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Asymptomatic Heart Disease</i> } DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes, Anemia</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Malnutrition</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <i>1979</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>7/28/79</i> , 19 <i>79</i> , to <i>8/2</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>8/2</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.					
22b. SIGNATURE <i>Constantine J Tan</i>		DEGREE	22c. DATE SIGNED <i>8/2/79</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Constantine J Tan</i>		22e. ADDRESS <i>547-D Riverside Dr. Salisbury, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>8-5-79</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Green Acres Mem. Pk.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Salisbury Wicomico Md</i>		
24. FUNERAL DIRECTOR NAME <i>Solley Memorial Chapel</i> ADDRESS <i>Rt. #2 Jersey Salis. Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 8 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Richard A. Barkley</i>	

100-100000

Peninsula General Hospital

AUG 1940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 is to be retained by the hospital or attending physician.

BP

DHMH - 16 60M 1/75  
(VR A 15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. 21043		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
RAY ALBERT BEERS				AUGUST 3 1979		10 1/2		M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Male		White		April 27, 1921		58		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Salisbury, Md.		USA				Wicomico MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital		Main. Sup.		State Hosp.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		Parker Road, Rt. 8	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Roy Augustus Beers		Etta Marie Grubb							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (wife) ADDRESS					
Yes		WW II		Mrs. Janice H. Beers Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):		410- Acute Myocardial Infarction						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b):							
		DUE TO, OR AS A CONSEQUENCE OF (c):							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. 79 8/11/79 to 8/3/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
O. J. Burton, M.D.						8/3/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
		Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		8/6/79 (Old)		Mardela Cemetery		Mardela, Wicomico, Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HOLLOWAY FUNERAL HOME, Salisbury, Md.				AUG 6 1979		[Signature]			



Wiscornico

Peninsula General Hospital

Salisbury

Acute Myocardial Infarction

Discharge Summary

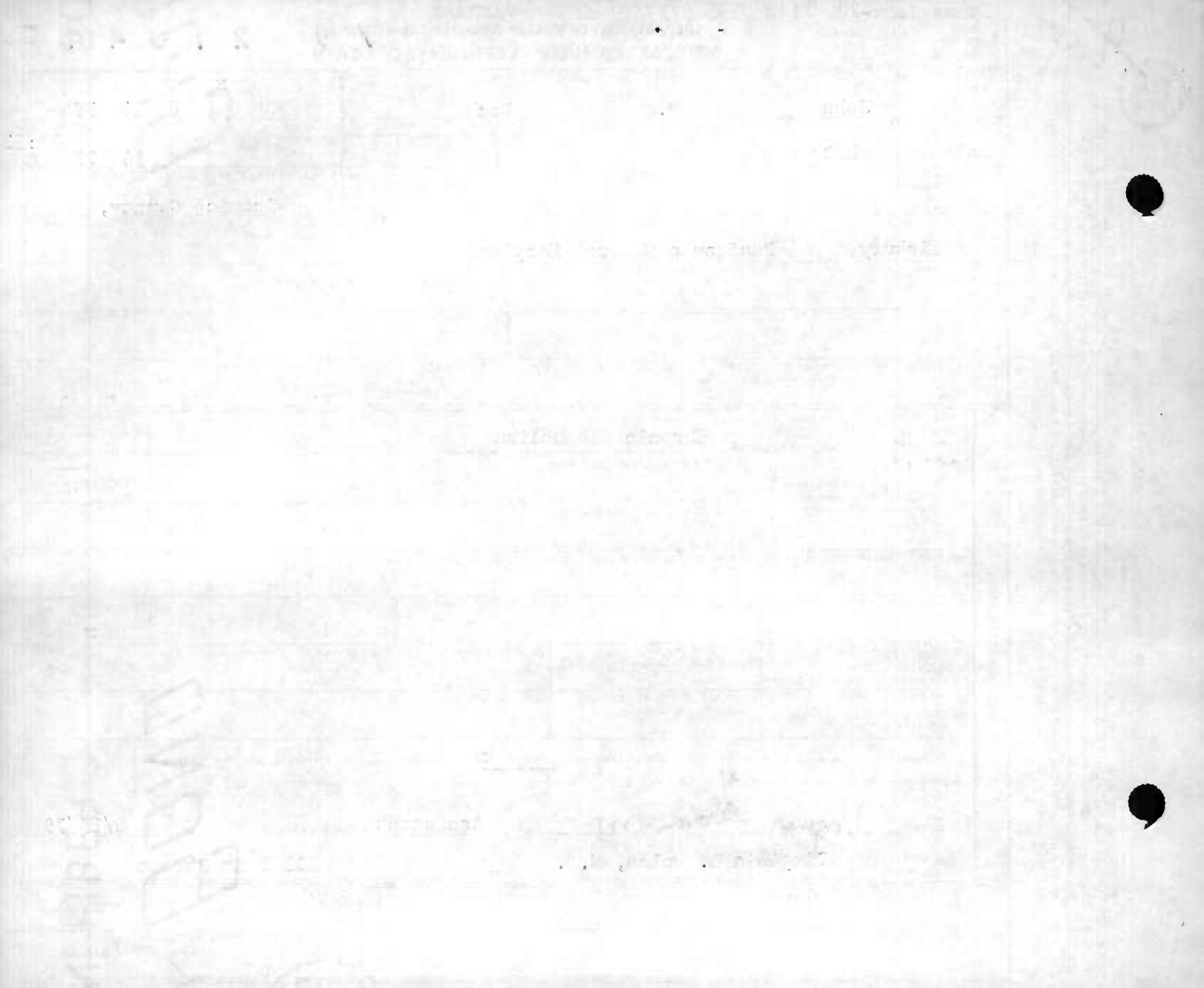
1/20/71 1/20/71 1/20/71  
1/20/71 1/20/71 1/20/71  
1/20/71 1/20/71 1/20/71

Items #10a-22a Film G535 9/19/79 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21044  
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
John		Dominick		Bock				8		14		19		79				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male	White	7/20/1934		45 YRS.						8		14		19		79		11:53 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
New Jersey		USA		WIDOWED		DIVORCED		Wicomico County, MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Salisbury		Peninsula General Hospital		Sales Manager		Insurance													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		1326 Middleneck Drive											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Cyrill M. Bock		Angeleno Greco																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (wife)		ADDRESS													
No				Mrs. Margaret A. Bock, Salisbury, Md.		P.O. Box 1221													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
303-		Chronic Alcoholism																	
		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
				(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
Virginia L. Dolan		Assistant		8/15/79															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
Virginia L. Dolan, M.D.		111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		8/20/79		Wicomico Memorial Park		Salisbury, Wicomico, Maryland													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
HOLLOWAY FUNERAL HOME,		Salisbury, Maryland		AUG 21 1979		[Signature]													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



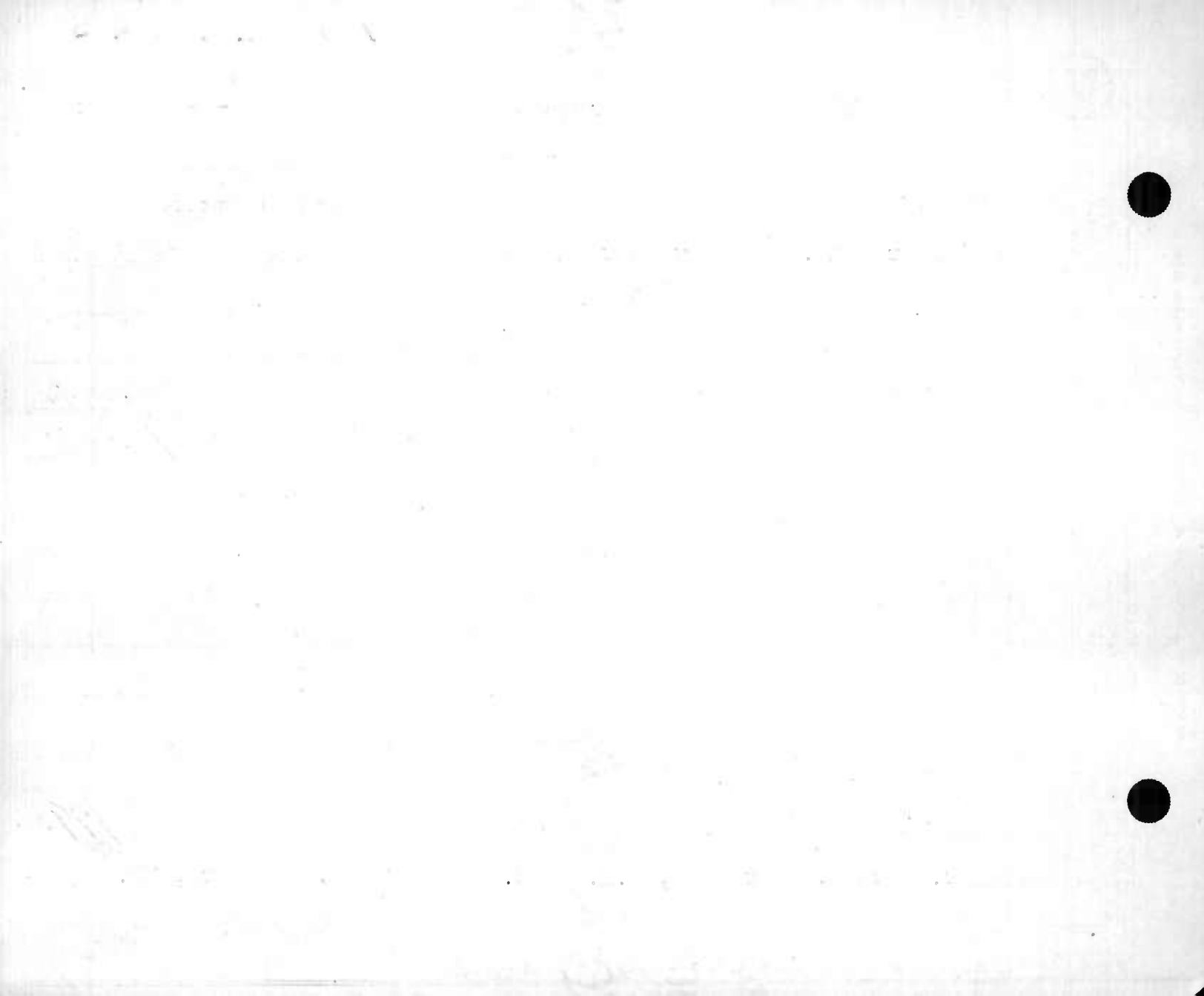
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 21045	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>Nellie</b>			FIRST <b>K.</b>			MIDDLE <b>Bounds</b>			LAST		
2a. DATE OF DEATH <b>8-6-79</b>			MONTH <b>8</b>			DAY <b>6</b>			YEAR <b>79</b>		
2b. HOUR <b>8:00</b>			A.M.			P.M.					
3. SEX <b>F</b>			4. RACE <b>W</b>			5. DATE OF BIRTH <b>4-24-94</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico County</b>		
10. CITY OR TOWN OF DEATH <b>Salisbury, Md.</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Salisbury Nursing Home</b>			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>OPERATOR</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>WIC</b>			13c. CITY OR TOWN <b>SALISBURY</b>			13d. INSIDE CITY LIMITS? <b>YES</b>		
14. FATHER'S NAME <b>J. WILSON BOUNDS</b>			FIRST <b>J.</b>			MIDDLE <b>WILSON</b>			LAST <b>BOUNDS</b>		
15. MOTHER'S MAIDEN NAME <b>RACHEL BAILEY</b>			FIRST <b>RACHEL</b>			MIDDLE <b>BAILEY</b>			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>216-07-3924</b>			17. INFORMANT <b>VICKI KATKINS</b>			ADDRESS <b>SALISBURY, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <b>4340</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last. <b>Due to OR AS A CONSEQUENCE OF</b> <b>Fractured hip</b> <b>Due to OR AS A CONSEQUENCE OF</b> <b>Fractured hip</b> <b>Due to OR AS A CONSEQUENCE OF</b> <b>Fractured hip</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>8/6/79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fractured hip</b>			20a. AUTOPSY? <b>YES</b>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/6 1979</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Fractured hip</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>HOME</b>			21f. LOCATION STREET <b>4/6</b>			CITY OR TOWN <b>Salisbury</b>		
21g. LOCATION COUNTY <b>WIC</b>			21h. LOCATION STATE <b>MD</b>			21i. LOCATION CITY OR TOWN <b>Salisbury</b>			21j. LOCATION COUNTY <b>WIC</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/6</b> 19 <b>79</b> to <b>8/6</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>8/5</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <b>Dr. Earl M. Beardsley</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8/6/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Earl M. Beardsley, M.D.</b>			22e. ADDRESS <b>Rt. 50 &amp; Civic Ave. Salisbury, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>8-8-79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>FIREMAN'S CEM</b>			23d. LOCATION CITY OR TOWN <b>SALISBURY</b>		
23e. LOCATION COUNTY <b>WIC</b>			23f. LOCATION STATE <b>MD</b>			23g. LOCATION CITY OR TOWN <b>Salisbury</b>			23h. LOCATION COUNTY <b>WIC</b>		
24. FUNERAL DIRECTOR NAME <b>WILSON FUNERAL HOME</b>			ADDRESS <b>SALISBURY, MD.</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1979</b>			25b. REGISTRAR'S SIGNATURE <b>John J. McBratney</b>		

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 alleges any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79	21046
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Thomas Gilbert Bradley</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>August 29 1979</b>			2b. HOUR <b>1P</b>			
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 23, 1912</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>					
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesperson</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7 Hatsawap Road</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Wesley Bradley</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie Twilley</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>218-03-7545</b>		17 INFORMANT ADDRESS <b>Mrs. Lenna Belle Bradley, Cambridge, Md.</b>						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic schistosomiasis</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Mo. Hrs.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>8-24</b> , 19 <b>79</b> , to <b>8-2</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased dying on <b>8-24</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
22b. SIGNATURE <b>[Signature]</b>					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-29-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 31, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cem. East New Mkt., Dor. Md.</b>				
24 FUNERAL DIRECTOR NAME <b>Thomas Funeral Home, Cambridge, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

BP

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

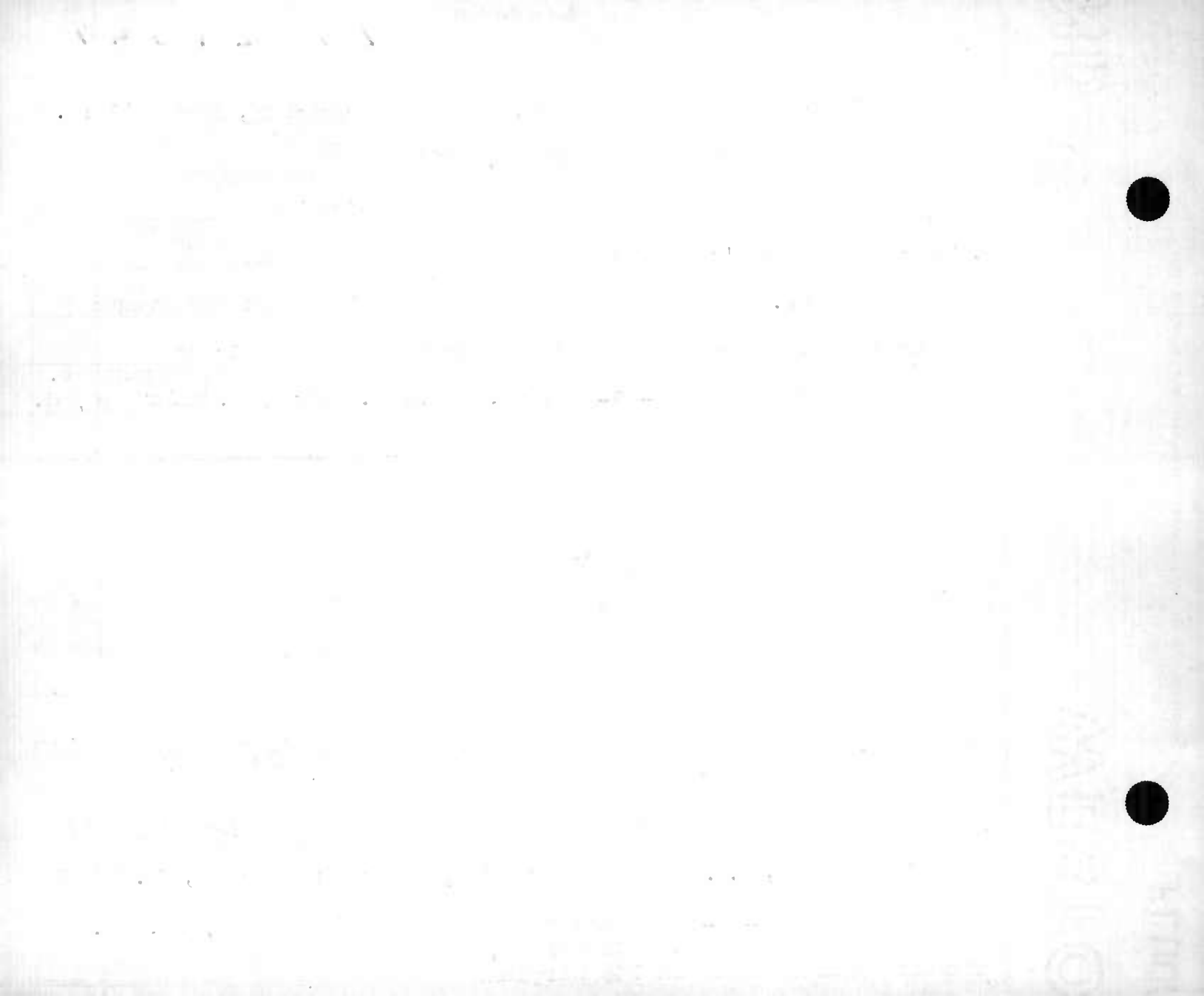
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 21047	
1. FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Winthrop Lee BRADSHAW</b>			2a DATE OF DEATH MONTH DAY YEAR <b>August 25, 1979</b>		2b HOUR <b>10:40 PM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 15, 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>US</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deer's Head Center</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>	
13a STATE <b>Maryland</b>		13b CITY OR TOWN <b>Dor. Cambridge</b>		13c STREET ADDRESS <b>208 West End Avenue</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Winthrop Bradshaw</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Cooke</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. <b>218-03-340</b>		17 INFORMANT ADDRESS <b>Mrs. James P. Swing, Jr. Cambridge, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>chronic myocardial Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>year</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>8/25</b> to <b>8/25</b> , 19 <b>79</b> , that (I) we last saw the deceased alive on <b>8/25</b> , 19 <b>79</b> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Inja Joe Hwang</b>		DEGREE <b>MD</b>		22c DATE SIGNED <b>8/25/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Inja Joe Hwang, M.D.</b>		22e ADDRESS <b>Deer's Head Center; Salisbury, Md. 21801</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>8-28-79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery Cambridge, Dor. Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Thomas Funeral Home Box 348 Maryland</b>		ADDRESS <b>Cambridge,</b>		25a DATE REC'D. BY REGISTRAR <b>AUG 31 1979</b>	
				25b REGISTRAR'S SIGNATURE <b>Pietro McCready</b>	



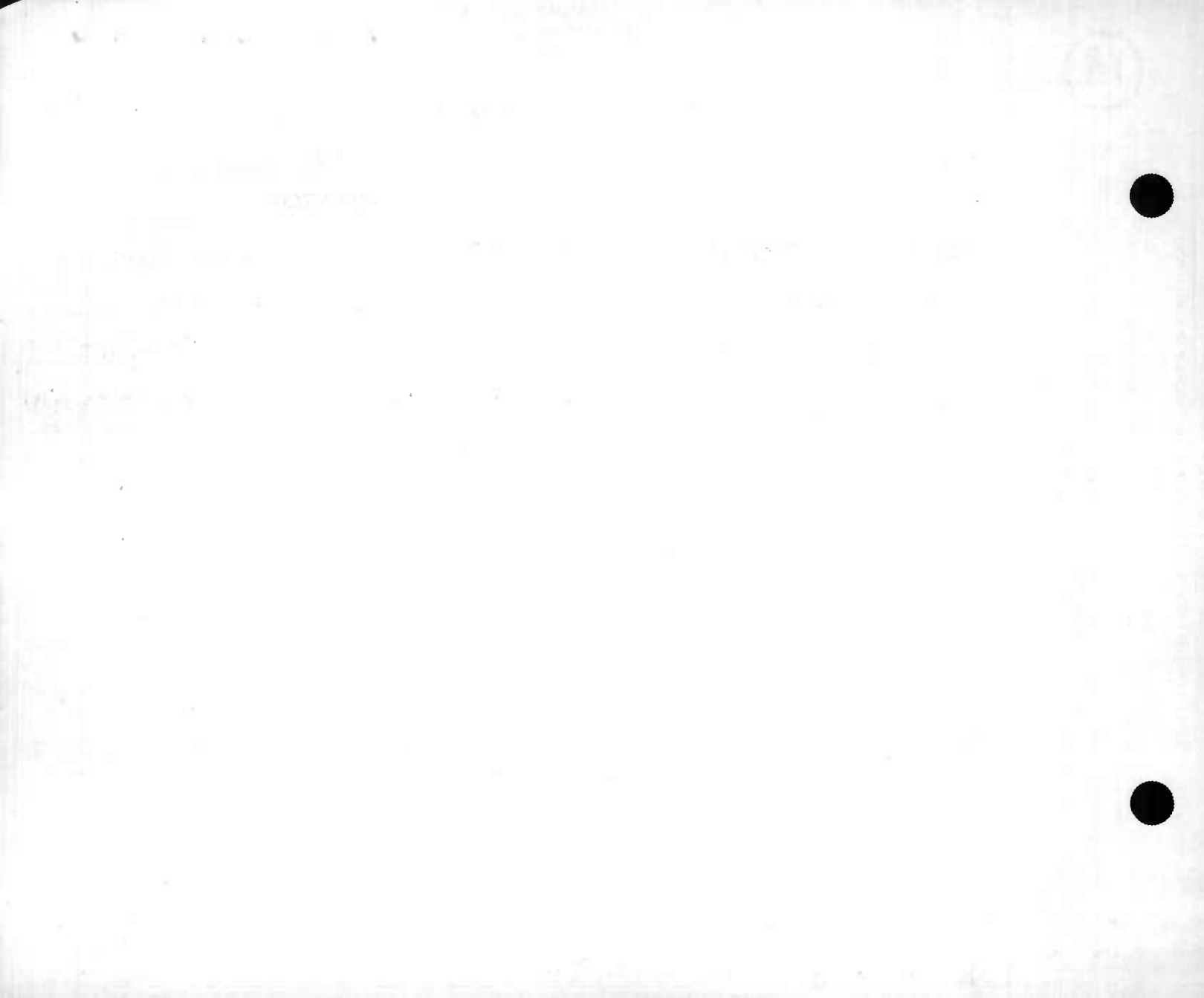
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 21048				
FOR 1. STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS H BRITTINGHAM</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 22, 1979</b>				2b. HOUR <b>3:15</b> M
3. SEX <b>MALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 12 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b> MD.			
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PENINSULA GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RET. LUMBERMAN.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD.</b>		13b. CITY OR TOWN <b>WOR.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>109 CEDAR AVE.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>SEWELL BRITTINGHAM</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA RAYNE</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>217-03-5926</b>		17. INFORMANT ADDRESS <b>FRANK L. BRITTINGHAM 319 N. Y AVE SALISBURY, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Acute Myocardial infarct</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alcohol Abuse</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hour</b> <b>hour</b> <b>yr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Cerebral Vascular Failure</b>									
19a. DATE OF OPERATION <b>8/22/79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. Certify that (I) (this hospital) attended the deceased from <b>8/22/79</b> to <b>8/22/79</b> , that (I) (we) last saw the deceased alive on <b>8/22/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John G Green</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/22/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN G GREEN</b>						22e. ADDRESS <b>215 OHIO AVE SALISBURY MD 21001</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>8/25/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. PLEASANT CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RURAL Wicomico Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Joan B. Pruttinger</b>						ADDRESS <b>108 Wm. St Berlin, Md.</b>		25. DATE REC'D. BY REGISTRAR <b>AUG 29 1979</b>	
						25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>			

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

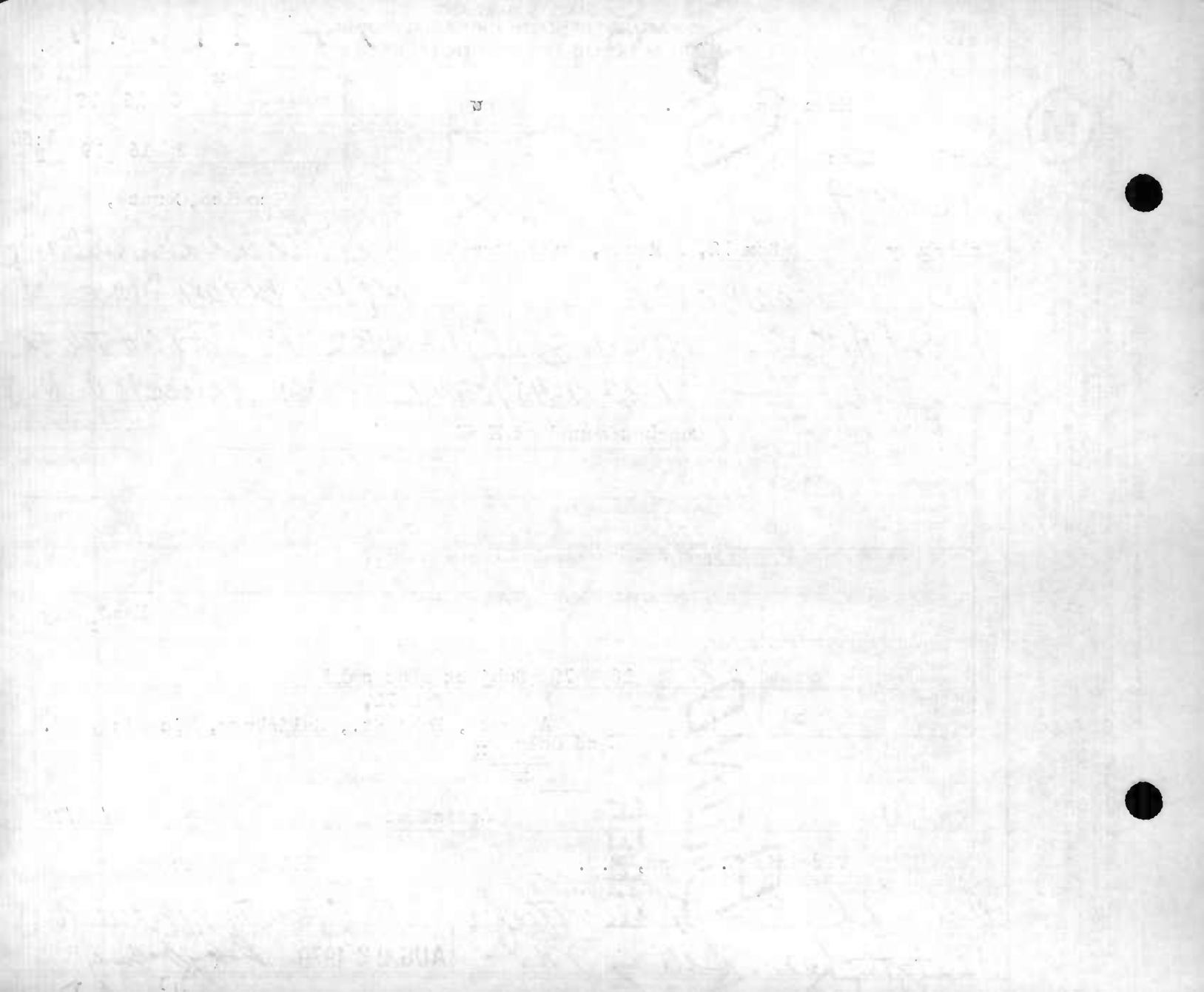
BP

DHMH - 17  
(VIR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21049  
REG. NO.

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		LAST	
Mercedes		O.		Brown	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE IN YEARS	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Female	Black	8-18-1939	39 YRS	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZENSHIP (U.S. OR FOREIGN)	7c. MARRIED		7d. NEVER MARRIED	
PENNA	U.S.A.	WIDOWED		DIVORCED	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12. USUAL OCCUPATION (TYPE OF WORK)		13. KIND OF BUSINESS OR INDUSTRY	
Salisbury	Box 72, A Route, Duke Street	Librarian		ST. Kelly	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.	
ADOLPHUS C	RYLANDER F	No		14212-1189	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Gunshot Wound of Head	
9554		DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)			
		DUE TO, OR AS A CONSEQUENCE OF			
		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				Head Only	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
Subject shot self		? P.M. 8 16 19 79		Subject shot self	
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION	
home		home		Box 72, A Route, Duke St., Salisbury, Wicomico, Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Virginia L. Dolan		Assistant		8/18/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Virginia L. Dolan, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		8-21-79		Princeton Cemetery, Princeton, New Jersey	
24. FUNERAL DIRECTOR		25a. DATE RECORDED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
West-Fork		AUG 22 1979		History McCreedy	



2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2 1 0 5 0

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Paul Frederick Burke</b>			2a. DATE OF DEATH Month Day Year <b>8 31 79</b>			2b. HOUR <b>11 30 M</b>			
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>5-20-08</b>		6. AGE (In years last birthday) YRS. <b>71</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Salisbury Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Minister</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Wor.</b>		13c. CITY OR TOWN <b>Berlin</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>R.F.D. Pathell Rd.</b>	
14. FATHER'S NAME First Middle Last <b>William Frederick Burke</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Lydia Stant</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-14-609A</b>		17. INFORMANT Address <b>Rev. Hugh G. Townsend, 211 Washington St. Berlin, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral thrombosis</b> <b>4340</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>generalized arterio sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>yes.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes Mellitus</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>UNDERLYING</b>		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/19</b> , 19 <b>79</b> , to <b>8/31</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>8/31</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John Paulley MD</b>				22c. DATE <b>9/1/79</b>		22d. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22e. ADDRESS									
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>Burial</b>		23b. DATE <b>9/4/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>First Baptist Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pocomoke Wor. Md.</b>			
24. FUNERAL DIRECTOR <b>Anna A. Burbage</b>		24b. ADDRESS <b>108 Williams St. Berlin Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 7 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>			



*[Faint, illegible text and markings are visible across the page, possibly bleed-through from the reverse side.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				21051			
1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT F. BURTON</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>8-26-79</b>						2b. HOUR <b>4:07A</b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>8</b> YEAR <b>20</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		2c. DATE PRONOUNCED DEAD <b>8-26-79</b>		2d. HOUR <b>"</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.							
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>crane operator</b>				12b. KIND OF BUSINESS <b>steel co.</b>							
13a. STATE <b>Md.</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk 21222</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8111 Murray Pt. Road</b>									
14. FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b>Burton</b> LAST <b>Burton</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Dolores</b> MIDDLE <b>Mills</b> LAST <b>Mills</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>W.W. II 401-12-8386</b>		17. INFORMANT (wife) <b>Virginia A. Burton, same as #13</b>				ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>8-26-79</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>				ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>															
23a. BURIAL, CREMATION, REMOVAL <b>burial</b>				23b. DATE <b>8-29-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Mem. Garden</b>				23d. LOCATION CITY OR TOWN <b>Baltimore, Md.</b> COUNTY STATE									
24. FUNERAL DIRECTOR <b>Brudzinski Funeral Home, Essex, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 29 1979</b>				25b. REGISTRAR'S SIGNATURE <i>Anthony A. Cressy</i>											



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21052

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HARRY FRANKLIN CAMPBELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 14 1979</b>			2b. HOUR <b>7:45</b> M				
3 SEX <b>M</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 - 27 - 92</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.				
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUCK CO. OWNER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TRUCKING</b>		
13a. STATE <b>PENNA</b>			13b. COUNTY <b>DELAWARE</b>		13c. CITY OR TOWN <b>MILLERSBORO</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>RFD #1</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>B. F. CAMPBELL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA SARVER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>180-26-6526</b>		17 INFORMANT ADDRESS <b>H. BEN CAMPBELL, MILLERSBORO, PA</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>436 -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Two weeks</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>7-25</b> , 19 <b>79</b> , to <b>8-14</b> , 19 <b>79</b> that (b) (we) last saw the deceased alive on <b>8-14</b> , 19 <b>79</b> , and that (c) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Roger C. Merrill</b>			DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8.14.79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROGER C. MERRILL</b>			22e. ADDRESS <b>KAY AVE SALISBURY MD 21801</b>							
23a. BURIAL CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>8/18/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEWPORT OLIVE TWP. PARRY CO. PA</b>			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Holloway Fun'l Home PA</b>			ADDRESS <b>Salisbury MD</b>		25. DATE REC'D. BY REGISTRAR <b>AUG 21 1979</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

10012 94

Wiscosis

Tennissola General Hospital

Palindromy

General Hospital

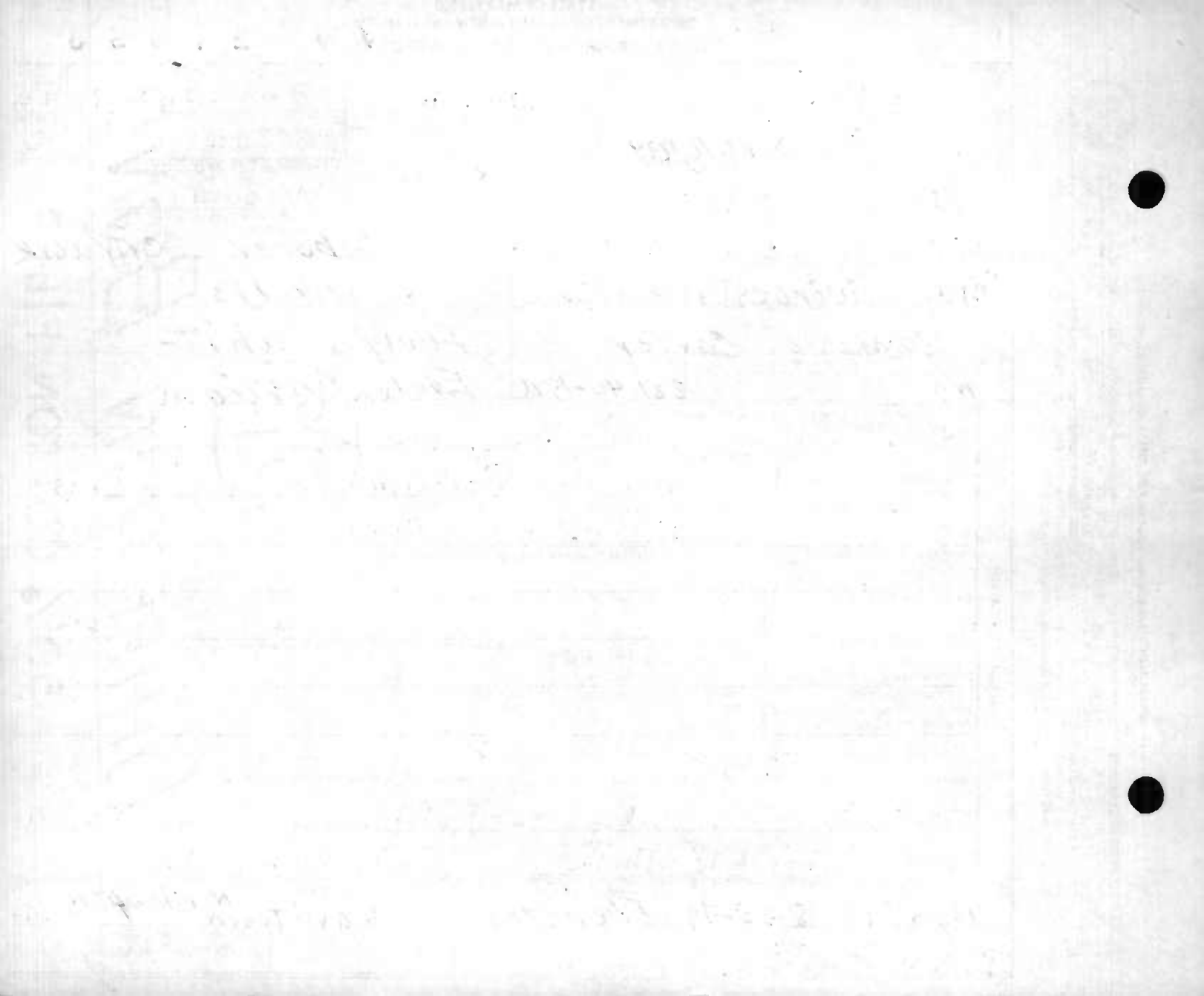
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21053											
1. DECEASED NAME (TYPE OR PRINT) <b>William</b>										FIRST <b>William</b> MIDDLE <b>Carter</b> LAST <b>Carter</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>Aug 16 1979</b>		2b. HOUR <b>9<sup>00</sup> AM</b>									
3. SEX <b>Male</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>SEP</b> DAY <b>10</b> YEAR <b>1934</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>44</b> YRS.		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		2c. DATE PRONOUNCED DEAD <b>Aug 16 1979</b>		2d. HOUR <b>9<sup>00</sup> AM</b>																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wilcomico</b> MD.																			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>laborer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>City work</b>																			
13a. STATE <b>MD.</b>				13b. COUNTY <b>Worcester</b>				13c. CITY OR TOWN <b>Berlin</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>Box 193</b>															
14. FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b>Carter</b> LAST <b>Carter</b>										15. MOTHER'S MAIDEN NAME FIRST <b>Evelyn</b> MIDDLE <b>White</b> LAST <b>White</b>																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>										16b. SOCIAL SECURITY NO. <b>227-40-7926</b>										17. INFORMANT ADDRESS <b>Evelyn Kelliam</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metabolic acidosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>hepatic failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>alcoholic cirrhosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hrs</b> <b>days</b> <b>yrs</b>																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																															
ACTUAL SIGNATURE <b>John G Bulkeley</b>										TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER										DATE SIGNED <b>8-17-79</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>John T Bulkeley</b>										ADDRESS <b>Salisbury, Md.</b>																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>										23b. DATE <b>8-20-79</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer</b>										23d. LOCATION CITY OR TOWN <b>Northampton Va.</b>	
24. FUNERAL DIRECTOR <b>Reed E. [Signature]</b>										ADDRESS <b>Accomac, Va. 22301</b>										25a. DATE REC'D. BY REGISTRAR <b>AUG 24 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

MEDICAL CERTIFICATION

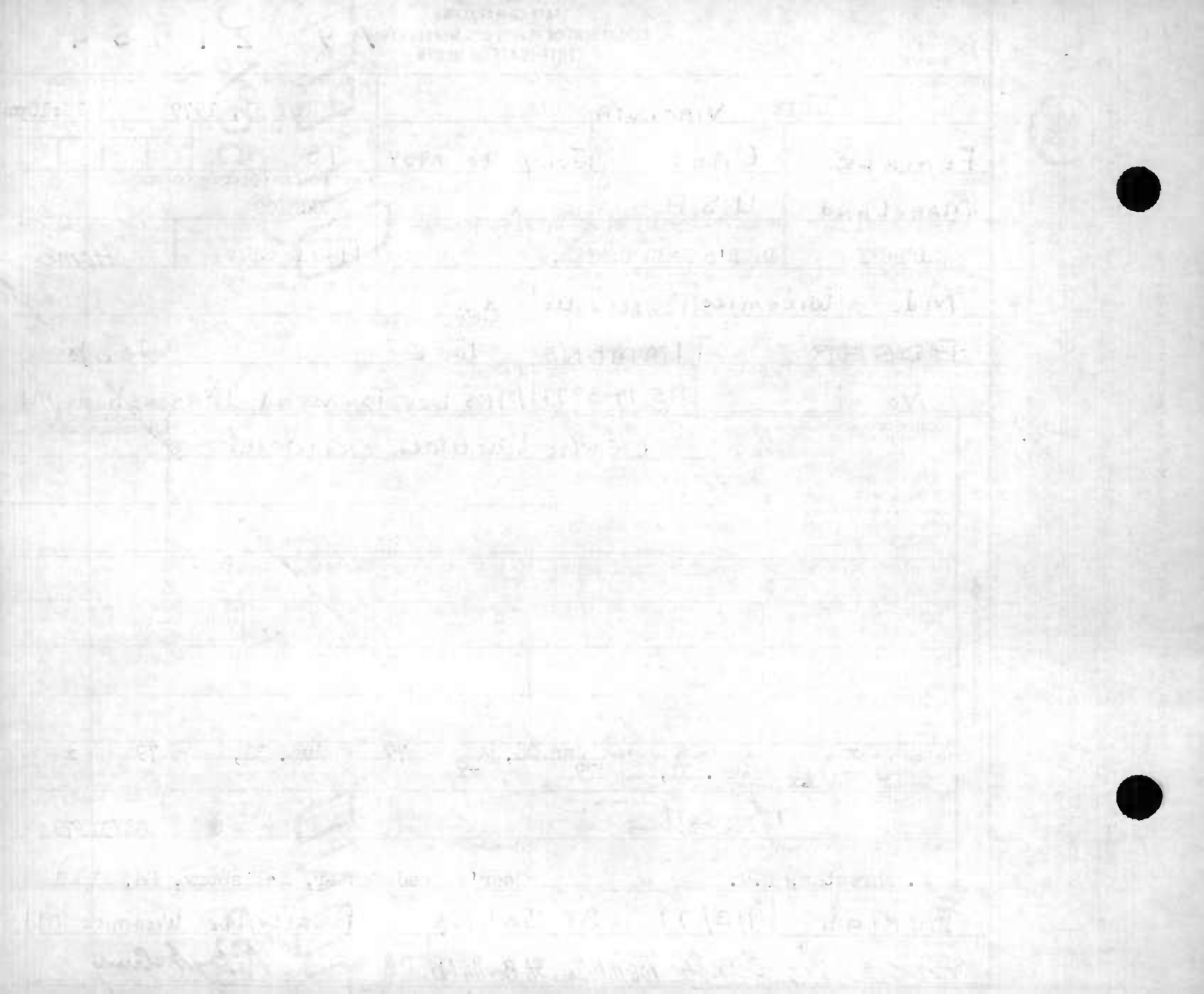


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 21054 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGIE VIRGINIA CLARK					2a. DATE OF DEATH MONTH DAY YEAR AUGUST 31, 1979			2b. HOUR 12:10pm	
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR July 20 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.			
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEER'S HEAD CENTER,			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Md. Wicomico POWELLVILLE					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
14. FATHER'S NAME FIRST MIDDLE LAST SEIDGER TIMMONS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEE Webb				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-14-3977		17. INFORMANT ADDRESS MRS. LEE TOWNSEND PARSONSBURG, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- Cerebro Vascular accident- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jun 08, 19 79, to Aug. 31, 19 79, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Aug. 31, 19 79, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Shrestha					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 08/31/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Shrestha, M.D.					22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/3/79		23c. NAME OF CEMETERY OR CREMATORY ST. Johns		23d. LOCATION CITY OR TOWN COUNTY STATE POWELLVILLE Wicomico Md.			
24. FUNERAL DIRECTOR NAME Anna A. Banker				ADDRESS 108 Williams St. Berlin Md		25a. DATE REC'D. BY REGISTRAR SEP 6 1979		25b. REGISTRAR'S SIGNATURE Ritzy McBrady	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21055

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert H. Cooper</b>			2a. DATE OF DEATH MONTH <b>AUGUST</b> DAY <b>26</b> YEAR <b>1979</b>		2b. HOUR <b>7:30 P.M.</b>
3 SEX <b>Male</b>	4 RACE <b>Negro</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>7</b> YEAR <b>1912</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tailor</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Dor.</b> 13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>809 Truman Ave.</b>		
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>B. C.</b> LAST <b>Cooper</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mable</b> MIDDLE <b>-</b> LAST <b>Brittingham</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-30-2489</b>		17. INFORMANT (Sister) ADDRESS <b>Mildred Anderson 514 Pine St. Camb., Md. 16</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>5860</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Ruptured Viscera</b> (c) <b></b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic Renal Failure Secondary to Nephrosclerosis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 26, 1979</b> to <b>Aug 26, 1979</b> , that (I) (we) last saw the deceased alive on <b>Aug 26, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Benito S. Chan MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/26/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BENITO S. CHAN</b>		22e. ADDRESS <b>547-D Riverside Dr. Salisbury</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel AME Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge, Dor. Md.</b>		24. FUNERAL DIRECTOR NAME <b>L.H. Boardley</b> ADDRESS <b>603 Washington St. Camb. Md</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 31 1979</b> 25b. REGISTRAR'S SIGNATURE <b>Lafayette McCreedy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 350-2000.

BP

Wichita

Salisbury Peninsula General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH M CORBIN						2a. DATE OF DEATH MONTH DAY YEAR 8 28 79		2b. HOUR 1 30 PM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5 22 1893		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIVERWALK MANOR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Somerset		13c. CITY OR TOWN Chance		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST Granville Webster				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Dashiell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-36-5365		17. INFORMANT Ruth Corbin Pre-arranged		17b. ADDRESS Chance, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from April 11, 1976, to Aug 28, 1979, that he (we) lost saw the deceased alive on Aug 28, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thomas C. Hill Jr.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/29/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. HILL JR.				22e. ADDRESS Pine Bluff Road, Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/79		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY Chance, Somerset Md.					
24. FUNERAL DIRECTOR Name James L. Hannon				ADDRESS Pineview Ave		25a. DATE REC'D. BY REGISTRAR SEP 4 1979		25b. REGISTRAR'S SIGNATURE L. J. McCreedy			

BP





FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21057  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR 6:35 M	
ROBERTA						COVINGTON				8-1-79		19					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	AA	7 28 03		76						8-1-79		19					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
N.C. CAROLINA		U.S.A.		WIDOWED		DIVORCED		Wicomico									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Salisbury		DOA Peninsula General Hospital		Reamster													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Rt. 50									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
WILLIAM		ESTELLA															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		220-26-3224		PAULINE HARMON		Rt 10 Salisbury											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
410-		Coronary Occlusion				sudden											
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE		SIGNED											
Earl L. Royer, M.D.		Deputy		8-2-79													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Earl L. Royer, M.D.		409 Camden Ave., Salisbury, Md.															
22b. BURIAL, CREMATION, REMOVAL		22c. DATE		22d. NAME OF CEMETERY OR CREMATORY		22e. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		8-5-79		Greenwood Mem. Pk. Salis		Wic		Md									
23. FUNERAL DIRECTOR NAME		ADDRESS		23a. DATE REC'D. BY REGISTRAR		23b. REGISTRAR'S SIGNATURE											
West-Fooks Funeral Home, Salisbury, Md.				AUG 6 1979													

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



BP ✓  
DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21058  
REG. NO.

FOR STATE REGISTRAR						MARRIED DECEASED MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO. 21058					
1. DECEASED NAME (TYPE OR PRINT)						20. DATE KNOWN OF DEATH						2b. HOUR					
FIRST MIDDLE LAST						MONTH DAY YEAR						ESTI. MONTH DAY YEAR					
1. DECEASED NAME (TYPE OR PRINT) W. Warren Cropper						20. DATE KNOWN OF DEATH 8-19-79						2b. HOUR 5:30 PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
M		W		JUNE 27 1900		79 YRS.		MONTHS DAYS		HOURS MIN.		Aug 19 1979		5:30 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?						9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND						U.S.A.						Wicomico MD					
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
BISHOPVILLE						PENINSULA GEN. HOSPITAL.						RET. FARMER					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE						13b. COUNTY						13c. STREET ADDRESS					
MARYLAND						WORCESTER						BISHOPVILLE					
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
ELBRIDGE L. CROPPER						LILLIE COLLINS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
(IF YES, GIVE YEAR OR DATES)						217-42-6072						MILLIE CROPPER BISHOPVILLE MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr yrs																	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE John S Bulkeley						TITLE (SPECIFY) Deputy						DATE SIGNED 8-20-79					
EXAMINER'S NAME (TYPE OR PRINT) John T Bulkeley						ADDRESS Salisbury Md.											
23a. BURIAL, CREMATION, REMOVAL						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY					
BURIAL						8-22-79						ODD FELLOWS					
23d. LOCATION (CITY OR TOWN) COUNTY STATE						23e. DATE REC'D. BY REGISTRAR						23f. REGISTRAR'S SIGNATURE					
BISHOPVILLE WORCESTER MD						AUG 27 1979											
31. FUNERAL DIRECTOR Peter Whaley Salisbury Md. 19975																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

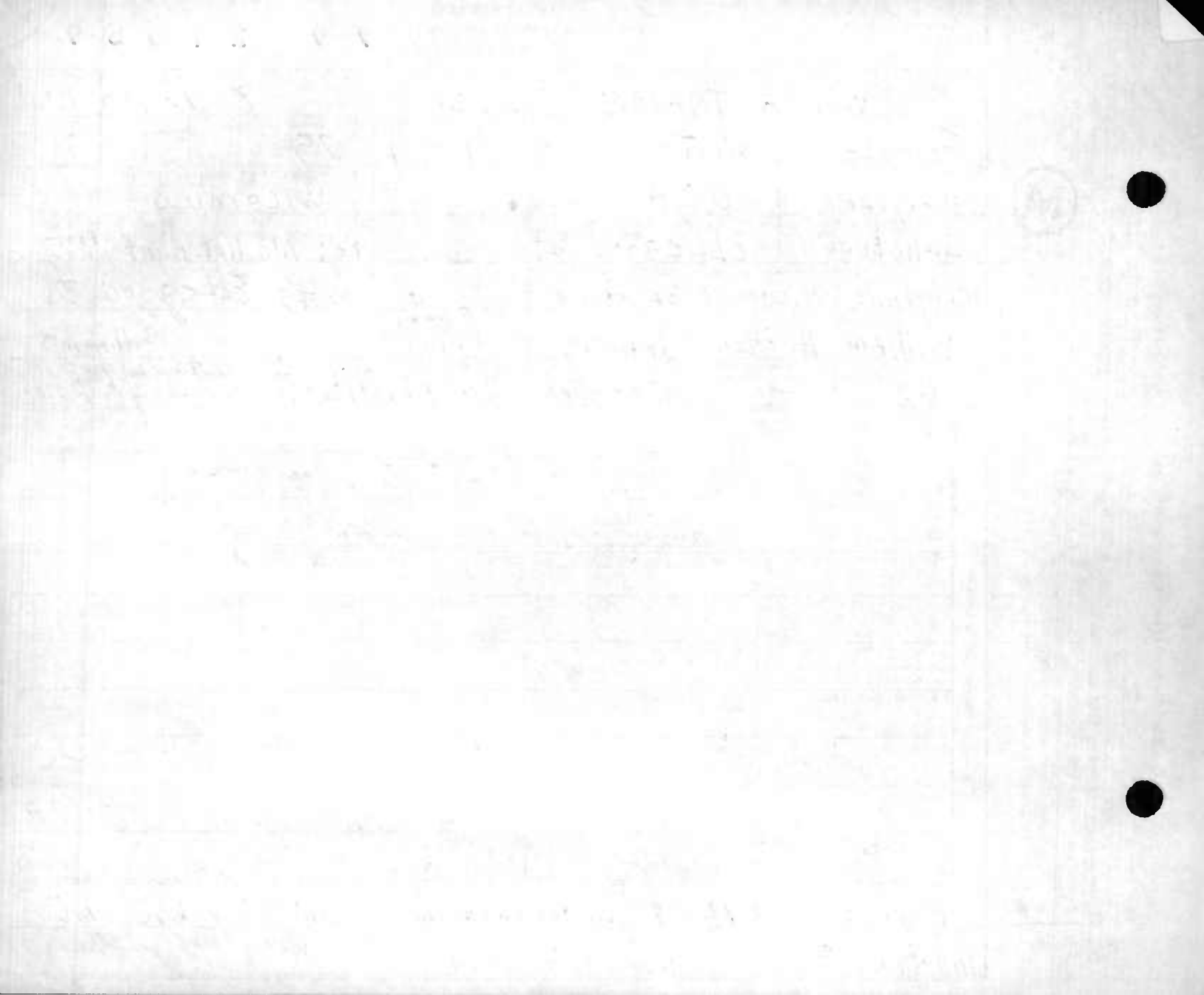
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

STATE OF MARYLAND

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLA TRAVERS CULVER</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>16</b> YEAR <b>1979</b>			2b. HOUR <b>9:30</b> P.M.					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>14</b> YEAR <b>1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		7. IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ELLEGOOD ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Md-Nat. BANK book</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>keeper</b>		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt #5 ELLEGOOD ST.</b>			
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>HUDSON</b> LAST <b>TRAVERS</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Carrie</b> MIDDLE <b>Williams</b> LAST <b>Williams</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>215-18-1568</b>		17. INFORMANT <b>MARY L. NIBLETT</b>				ADDRESS <b>Rt #5 ELLEGOOD ST Salisbury, Md 21801</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>1830</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Disseminated adenocarcinoma of ovary</b> (c) <b>Primary cystic adenocarcinoma of ovary</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION <b>9/9</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>6/26/78</b> 19 <b>78</b> to <b>8/16</b> 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>8/15</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Phyllis A Insley</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>8/21/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Phyllis A Insley</b>						22e. ADDRESS <b>Medical Center Salisbury, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>8/19/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wic MD</b>			
24. FUNERAL DIRECTOR NAME <b>Hill-Baker-Bounds</b> ADDRESS <b>Salisbury, Md 21801</b>						25a. DATE REC'D BY REGISTRAR <b>AUG 23 1979</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21060

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>CHARLES TILDON DASHIELL JR</b>			2a DATE OF DEATH MONTH DAY YEAR <b>AUGUST 20 1979</b>			2b HOUR <b>9:30</b> M						
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>April 25, 1916</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Quantico, Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD						
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Candy product.</b>				
13a STATE <b>Maryland</b>			13b COUNTY <b>Wicomico</b>		13c CITY OR TOWN <b>Salisbury</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>PineKnoll Terrace</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles Tildon Dashiell</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Rencher</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WW II 220-10-8498</b>		17 INFORMANT (wife) ADDRESS <b>Mrs. Irene L. Dashiell same as 13</b>							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Obstructive Jaundice</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic carcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>6 months</b>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (a) (this hospital) attended the deceased from <b>7-23</b> 19 <b>79</b> to <b>8-20</b> 19 <b>79</b> , that (b) the deceased alive on <b>8-20</b> 19 <b>79</b> , and that in (c) my (your) opinion death occurred on the date and hour and from the causes stated (d) I did not view the body after death												
22b SIGNATURE <b>Roger C Merrill</b>						DEGREE <b>MD</b>		22c DATE SIGNED <b>8-20-79</b>				
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROGER C MERRILL</b>						22e ADDRESS <b>1445 AVE SALISBURY Md. 21801</b>						
23a BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>			23b DATE <b>8/22/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury, Wic., Md.</b>					
24 FUNERAL DIRECTOR NAME ADDRESS <b>HOLLOWAY FUNERAL HOME, Salisbury, Md.</b>						25a DATE REC'D. BY REGISTRAR <b>AUG 23 1979</b>		25b REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

BP

2 4 0 0 0

Peninsula General Hospital

Salisbury

Widdowson

2 4 0 0 0

Widdowson  
2 4 0 0 0

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 21061

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles Franklin David			2a. DATE OF DEATH MONTH DAY YEAR August 28, 1979			2b. HOUR 1:10 P.M.	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11-17 1913		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	
12b. KIND OF BUSINESS OR INDUSTRY Gas Station							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 916 S. Division St.							
14. FATHER'S NAME FIRST MIDDLE LAST Charles David				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Slaughter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-09-9495		17. INFORMANT ADDRESS Fruitland, Md. 21826 Ruth McCann Box 62 Bonach Trailer Ct			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Obstructive Lung Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Benito S. Chan MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENITO S. CHAN		22e. ADDRESS 544-D Riverside Drive			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-1-1979		23c. NAME OF CEMETERY OR CREMATORY Delmarve Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Delaware	
24. FUNERAL DIRECTOR NAME Holloway Funeral P.A. Salisbury, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 4 1979		25b. REGISTRAR'S SIGNATURE Holloway Funeral P.A.	

16  
80  
35  
22  
1

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of place.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

101

101

101

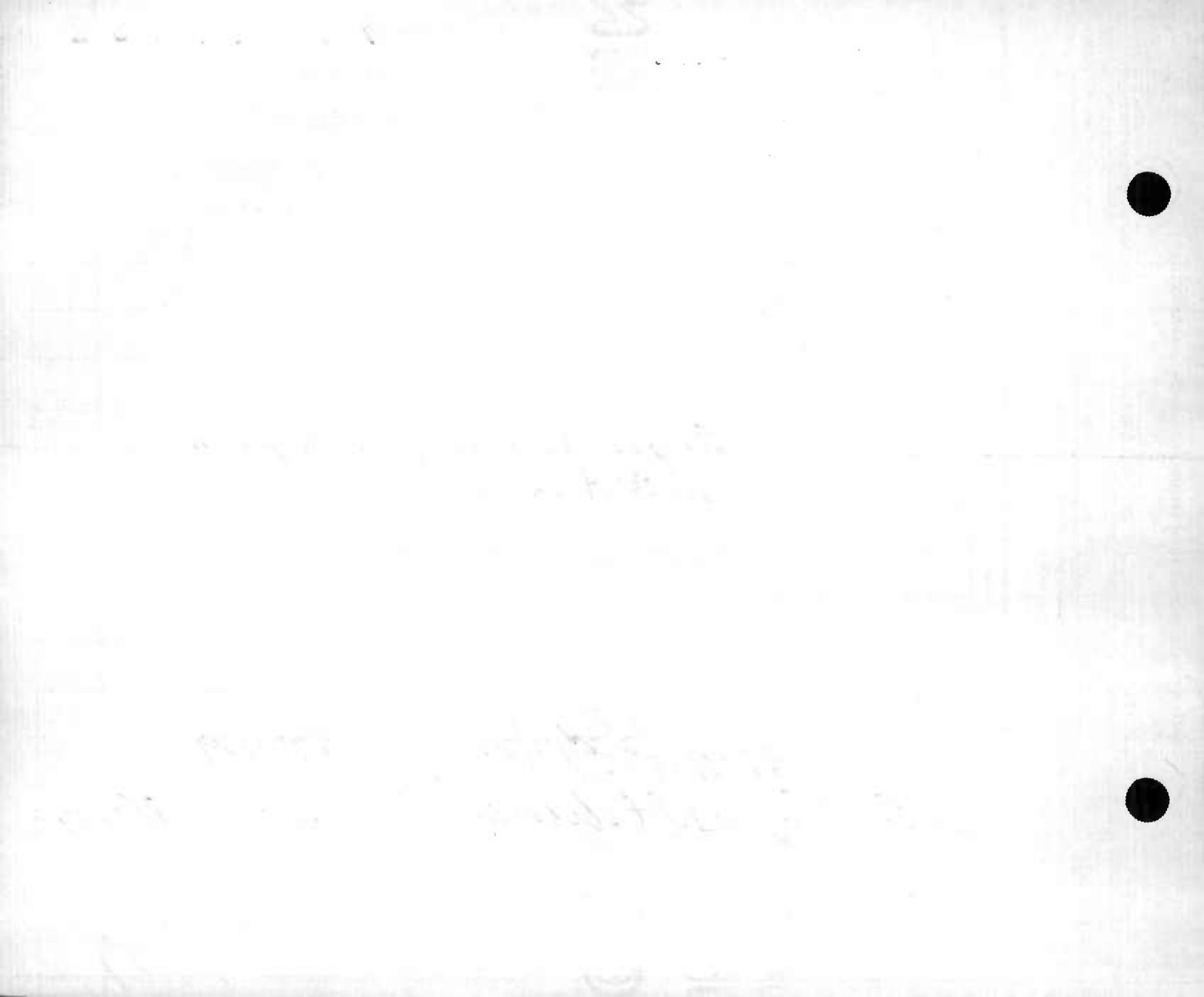
101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 9 21062				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma Elizabeth Davis					2a. DATE OF DEATH MONTH DAY YEAR 8-30-79			2b. HOUR 3:40 PM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11/15/1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Manticoke, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wicomico Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady & Cashier		12b. KIND OF BUSINESS OR INDUSTRY -Shoes	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 521 Alabama Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST James A. White					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Messick				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-9506		17. INFORMANT (daughter) ADDRESS Rt. 3, Mrs. Nelda D. Guthrie, Salisbury, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angio Sarcoma &amp; widespread</u> 1719 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13/79</u> 19_____, to <u>8/30/79</u> 19_____, that (I) (we) last saw the deceased alive on <u>8/30/79</u> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURES <u>A. C. Mitchell</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 8/31/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. C. Mitchell, M.D.					22e. ADDRESS Fruitland, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/3/79		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic. Maryland			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.					25a. DATE REC'D. BY REGISTRAR SEP 6 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony Mitchell</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					7 9 2 1 0 6 3 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) EUNICE BRITTINGHAM DENNIS					2a. DATE OF DEATH MONTH DAY YEAR AUGUST 15 1979						
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 1 4 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7b. HOUR 2 53 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec. Salisbury State College		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George HANDY BRITTINGHAM					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche JACKSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-07-7473		17. INFORMANT ADDRESS George F. DENNIS 823 E. Church St. Salisbury, Md 21801				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>increased intracranial pressure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>thalamic glioma</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last <u>1910</u> <u>none</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u>											
19a. DATE OF OPERATION <u>none</u>					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <u>8-15</u> , 19 <u>79</u> , to <u>8-15</u> , 19 <u>79</u> , that (b) (we) lost saw the deceased alive on <u>8-15</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 8/15/1979.	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) James Wilson Spence					22c. ADDRESS Medical Center Salisbury, Md 21801						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL					23b. DATE 8/18/1979		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wic. Md.		
24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds					ADDRESS Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR AUG 21 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

© 2000 Blackwell Science Ltd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7. 9 21064				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur (none) Dix					2a. DATE OF DEATH MONTH DAY YEAR August 12 1979			2b. HOUR MIN 3:30 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 2-1909		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 70		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wterman		12b. KIND OF BUSINESS OR INDUSTRY Seafood	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Virginia					13c. CITY OR TOWN Northampton Cape Charles		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur (none) Dix					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Tyler				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 227 10 5188		17. INFORMANT ADDRESS Warren Dix Cape Charles, Va. 23310					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Renal failure; acidosis DUE TO, OR AS A CONSEQUENCE OF (b) Massive Vascular Thrombosis, legs DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic occlusive disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days 3 years -
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 8/11/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED, Thrombosis, leg grafts + arteries				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/11 1979, to 8/12 1979, that (I) (we) last saw the deceased alive on 8/12 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE William P. Sadler M.D.					22c. DATE SIGNED 8/14/79			22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. Sadler	
22e. ADDRESS S. Division Street, Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 14, 1979		23c. NAME OF CEMETERY OR CREMATORY Cape Charles		23d. LOCATION CITY OR TOWN Cape Charles		23e. STATE Va.	
24. FUNERAL DIRECTOR NAME F. N. F. F.		24b. ADDRESS 23310		25a. DATE REC'D. BY REGISTRAR AUG 23 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

Salisbury Penitentiary General Hospital

Wilmington

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Frederick Dooley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 26 1979</b>		2b. HOUR <b>5:15</b> M
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 4, 1920</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Vermont</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Field Representative</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Tax Collection</b>	
13a. STATE <b>Md</b>	13b. CITY OR TOWN <b>Prince Georges Adelphia</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS <b>9214 Tuckahoe Lane</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Francis Dooley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline - Bounds</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <b>Yes W.W.II, Korea</b>		16b. SOCIAL SECURITY NO. <b>008-10-5995</b>	17. INFORMANT ADDRESS <b>Mrs. Virginia Dooley, 9214 Tuckahoe Lane</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Hypertension</b>					
19a. DATE OF OPERATION <b>8/20/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Appendectomy</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/20/79</b> to <b>8/22/79</b> , that (I) (we) last saw the deceased alive on <b>8/20/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John J. Green</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>8/26/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John J. Green</b>		22e. ADDRESS <b>Ohio Ave. Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8/30/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Springs Mont. Co. Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>AUG 28 1979</b>	
24. FUNERAL DIRECTOR NAME <b>Anne A. Buehler</b>		ADDRESS <b>108 Williams St., Berlin, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Pietro A. Brady</b>	

MEDICAL CERTIFICATION



26

7302

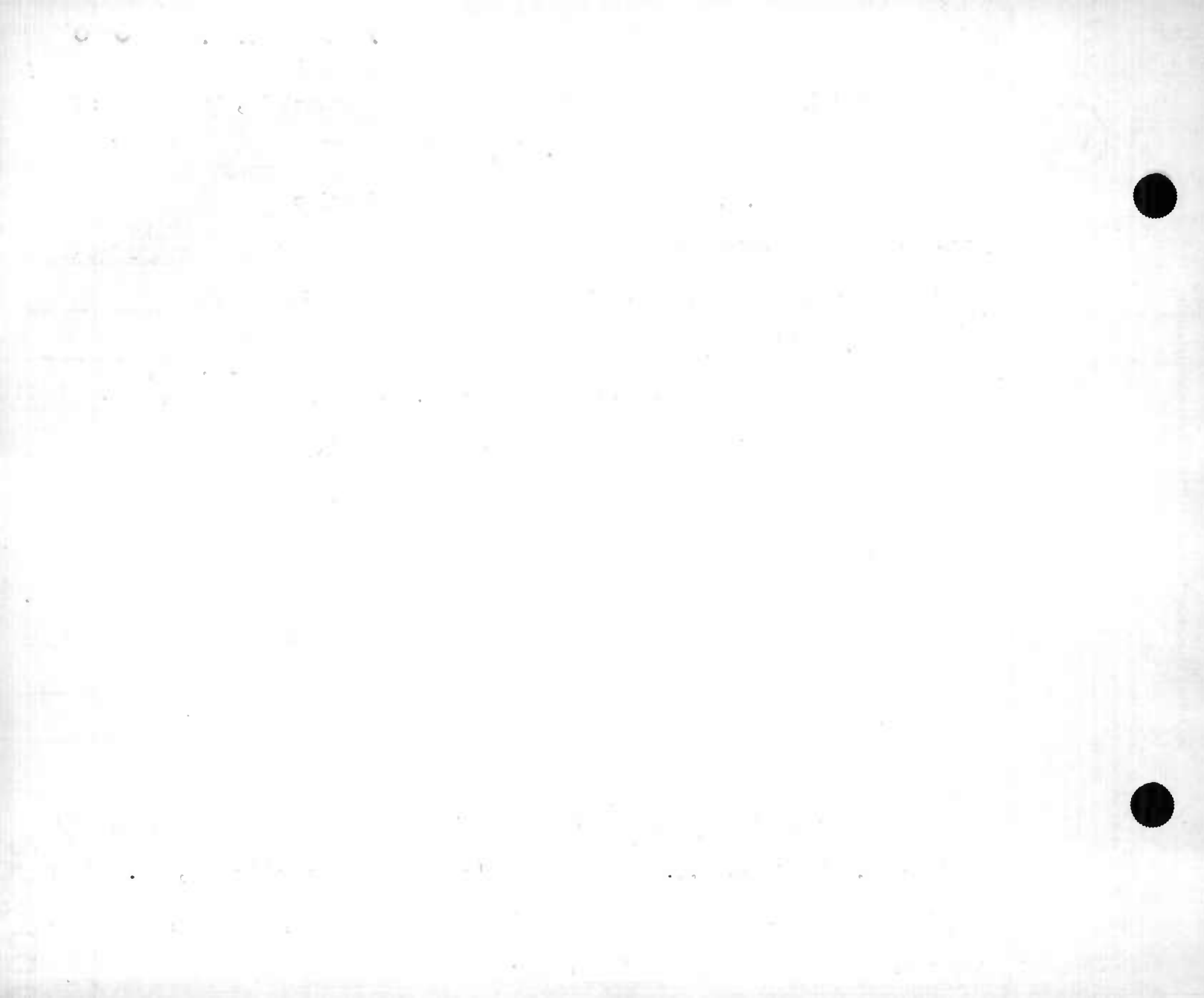
12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR			REG. NO. 9 21066							
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
Orville KENNETH DULIN			August 18, 1979				9:40 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
male		caucasian		Mar. 16, 1902		77 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.				Wicomico MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Deer's Head Center				parts clerk		manufacture		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE 13b. COUNTY Maryland Queen Anne Stevensville					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Main Street			
14. FATHER'S NAME (FIRST MIDDLE LAST)					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)					
Harry D. Dulin					Bessie Kennard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no			195-05-9975		Thelma D. Vaughn		R.D. #3, Bx 786 Easton, Md. 21601			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular d.</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE					22c. DATE SIGNED		
Edward P. Ritchings, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					6/18/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
Edward P. Ritchings, M.D.			Deer's Head Center; Salisbury, Md. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			8-21-1979		Spring Hill		Easton, Talbot, Maryland			
24. FUNERAL DIRECTOR NAME					24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Newnam Funeral Home					Easton, Md.		AUG 21 1979			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) Nina Warfield Dykes			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 28 1979		2b. HOUR 25 TA M		REG. NO. 9 21067			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 29 1901		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.				
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Fruitland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 118 Moore Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST David			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-32-5596		17. INFORMANT ADDRESS Mrs. Mary A. Poso 113 Moore Ave. Salisbury, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chest Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/28</u> , 19 <u>79</u> , to <u>8/29</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8/28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Joseph A. Grassi</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-30-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grassi			22e. ADDRESS PGHMC, SALISBURY, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-1-79		23c. NAME OF CEMETERY OR CREMATORY Springhill Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md			
24. FUNERAL DIRECTOR NAME Holloway Funeral Home			ADDRESS P.A. Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR SEP 4 1979		25b. REGISTRAR'S SIGNATURE <u>Holloway</u>		

NOV 1 1958

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 21068

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		August 17 1979		9:40 P.M.	
WILMER ALLEN Dykes							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		MONTH DAY YEAR		74	
				Dec. 27, 1904		YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Salisbury, Md., USA		USA				Wicomico MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital		Farmer		Farming	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS	
Maryland		Wicomico		Salisbury		519 Dykes Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
Ernest P. Dykes		Mrs. Caroline Pryor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		217-14-8305		Mrs. Nina P. Dykes (wife)		same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Myocardial infarction & shock							
410- DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-17, 1979, to 8-17, 1979, that (I) (we) lost saw the deceased alive on 8-17, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
EJ Ghell		MD		8-17-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Colwell		PGH, Salisbury MD 21881					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		8/21/79		Wicomico Memorial Park		Salisbury, Wic., Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HOLLOWAY FUNERAL HOME, Salisbury, Maryland		AUG 22 1979		P. H. McQuay			



Wilmington

Peninsula General Hospital

Salisbury

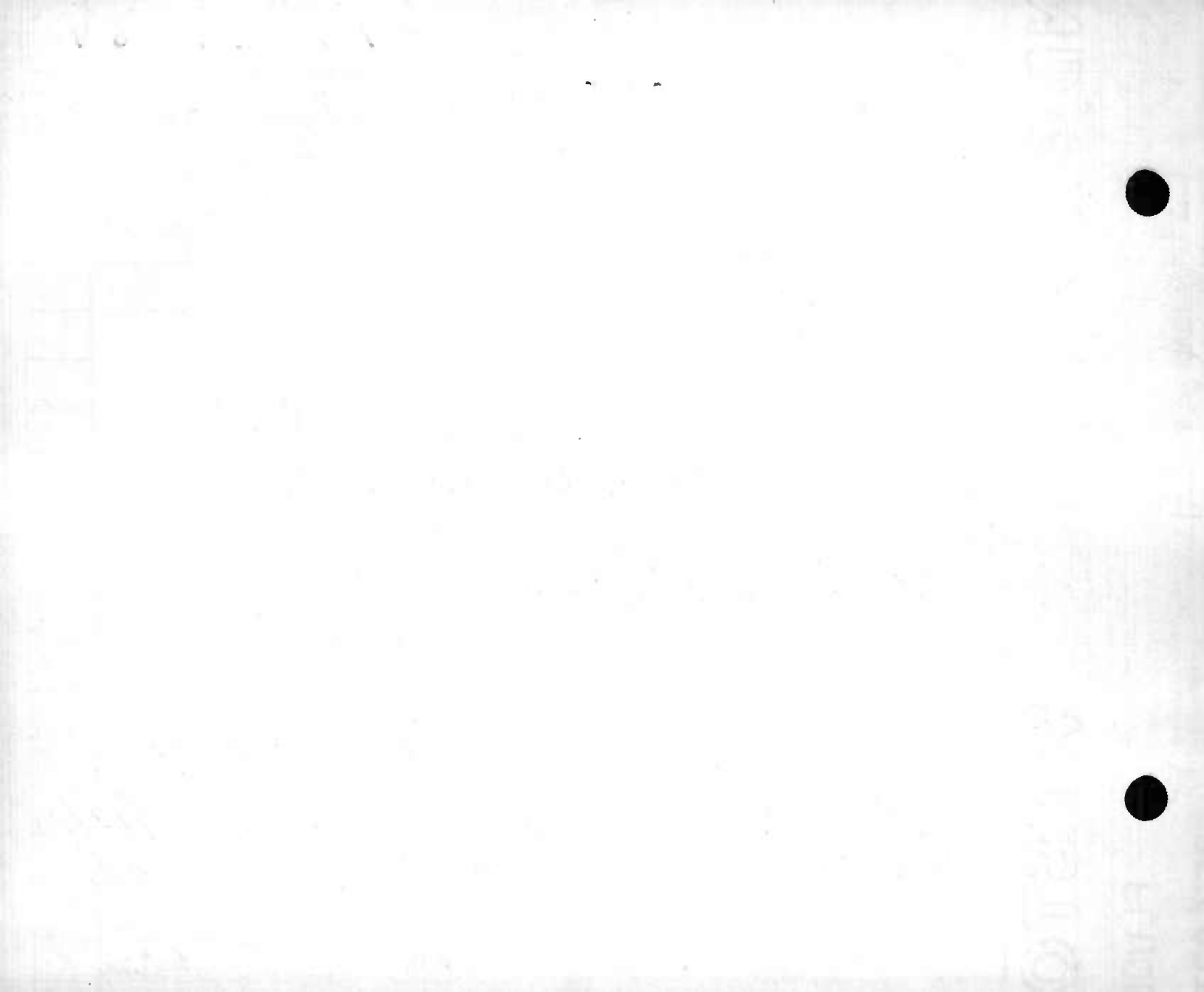
00000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

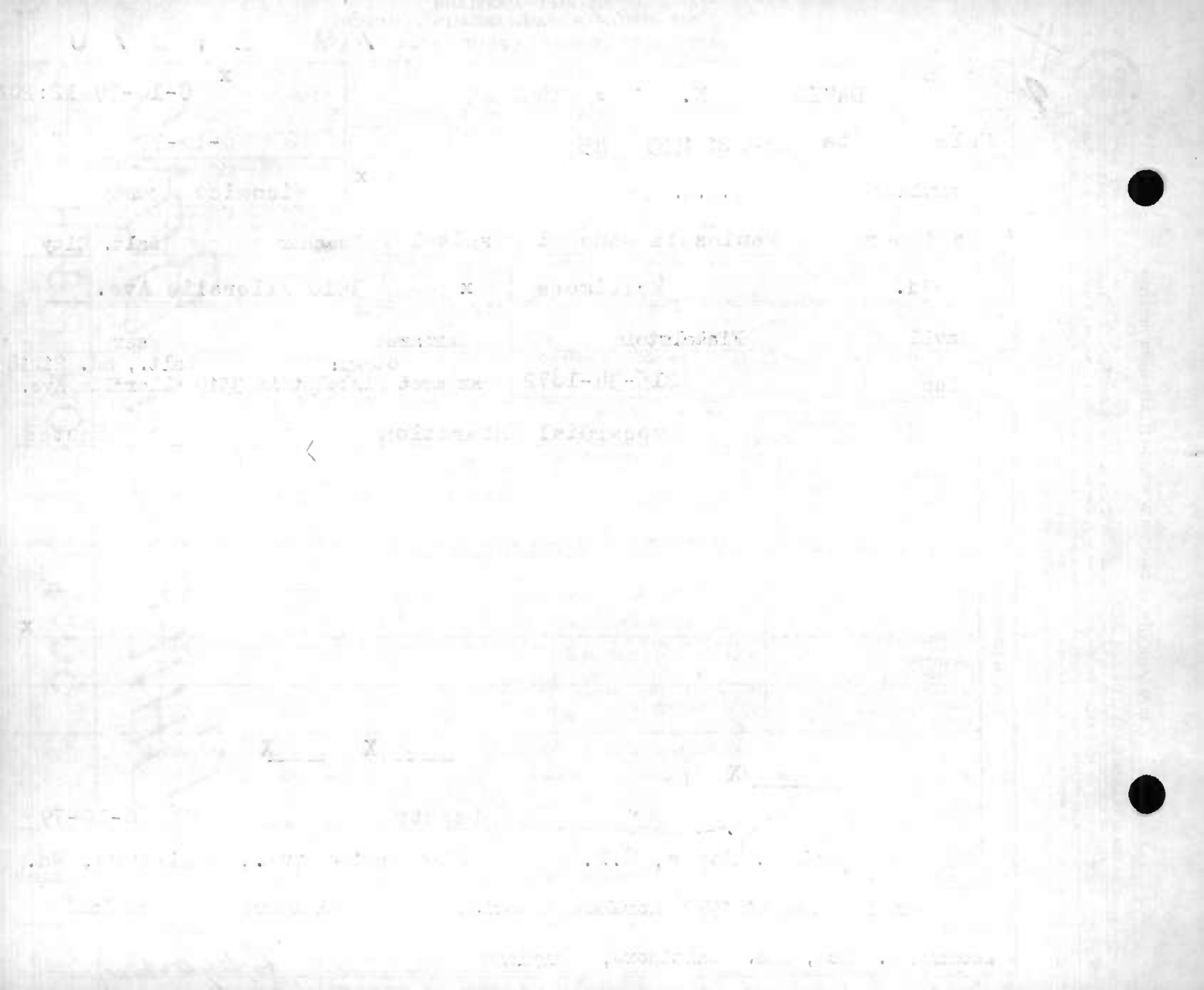
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		9 21069 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR M	
E dythe		C.				Feaster		8 - 12, 79		12 Noon	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
F		W		6 6 93		86					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Townsend, Md.		USA				WICOMICO MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Wicomico Nursing Home						Housewife		none	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Pr. George		Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		2214 Charleston Place			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]		16b. SOCIAL SECURITY NO.		17 INFORMANT (son) ADDRESS			
Samuel F. Cooke		Bertha E. Ward		No				Mr. Rexford H. Feaster, Rt. 1, Box 306 Princess Anne, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident,</u> <u>436 -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoma of bladder &amp; metastases</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-16</u> , 19 <u>79</u> , to <u>8-12</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8-8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. C. McNeill</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/13/79</u>					
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS									
A.C. McNeill		POB 2378 Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		8/16/79		Arlington National		Cem. Arlington		Virginia			
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
HOLLOWAY FUNERAL HOME,		Salisbury, Md.		AUG 16 1979		<u>R. McNeill</u>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 21070									
FOR 1- STATE REGISTRAR									
1. DECEASED NAME FIRST MIDDLE LAST DAVID K. FINKELSTEIN									
2a. DATE KNOWN OF DEATH		2b. DATE OF ESTI-MATED DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR		2e. HOUR	
8-10-79		8-10-79		8-10-79		12:20A		12:20A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 21 1933		6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Balt. City	
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3510 Ellerslie Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST David Finkelstein					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Eser				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 215-34-1872		17. INFORMANT Mother: ADDRESS Margaret Finkelstein 3510 Ellerslie Ave. Balt., Md. 21218				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 8-10-79	
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 21 1979		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 13 1979		25b. REGISTRAR'S SIGNATURE L. J. Ruck	



BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21071
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>James J Fromm</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8 4 1979</b>		2b. HOUR <b>3:02 P M</b>
3. SEX <b>M</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 25 05</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>73 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8 4 1979</b>		2d. HOUR <b>3:03 P M</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico MD.</b>				
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula Sanit Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto dealer</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Virginia</b>		13b. COUNTY <b>Northampton</b>		13c. CITY OR TOWN <b>Machipongo</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>US RTE. 13 23405</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Fromm</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Romie</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Unknown</b>				16b. SOCIAL SECURITY NO. <b>207-01-1228</b>		17. INFORMANT ADDRESS <b>Grace Siegfried Fromm, Machipongo, Va 23405</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of Skull</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2017 8 4 1979 P.M.</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Passenger Auto Accident</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Hiway</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt 13 Oak Hall Accomac Va</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>Earl L. Royer</b>			TITLE (SPECIFY) M.D. <b>Deputy</b> MEDICAL EXAMINER			DATE SIGNED <b>8-4-79</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer</b>			ADDRESS <b>Salisbury, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/8/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Easton, Pa.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton, Pa.</b>			
24. FUNERAL DIRECTOR <b>James N. Fox</b>			ADDRESS <b>Temperanceville, Va.</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey MacCreedy</b>		

1941





BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												21072																							
1. DECEASED NAME (TYPE OR PRINT)						FIRST MOIR						MIDDLE M.						LAST FULKS						2a. DATE KNOWN OF DEATH				2b. HOUR																			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR																															
Male		White		6 12 17		62 YRS.						8-31-79				11																															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH																													
N.C.						U.S.A.												Wicomico MD.																													
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY																													
Salisbury						DOA Peninsula General Hospital						Contract Manager						Bus. Machines																													
13a. STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS?						13e. STREET ADDRESS																							
Md.						Worcester						Ocean City						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						902 Blue Water E., 134th St. Coastal Highway																							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																																									
B. Friel						Fulks						Frances						Hawks																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT						ADDRESS																													
Yes						W.W. II						579-18-5705						Mrs. Mary J. Fulks						902 S. Blue Water E. 134th St. Coastal Hwy																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																			
IMMEDIATE CAUSE (a) Coronary Occlusion												hours																																			
410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																																															
(b)																																															
DUE TO, OR AS A CONSEQUENCE OF																																															
(c)																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																															
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?																							
																								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19												21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>												21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)												21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																															
ACTUAL SIGNATURE												TITLE (SPECIFY) Deputy												DATE SIGNED																							
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS																																			
Earl L. Royer, M.D.												409 Camden Ave., Salisbury, Md.																																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial												9/4/79												Sunset Memorial Park												Berlin R.F.D. Wor. Md.											
24. FUNERAL DIRECTOR												ADDRESS												25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE											
Burbage Funeral Home												108 Williams St.												SEP 7 1979												R. J. McBrady											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

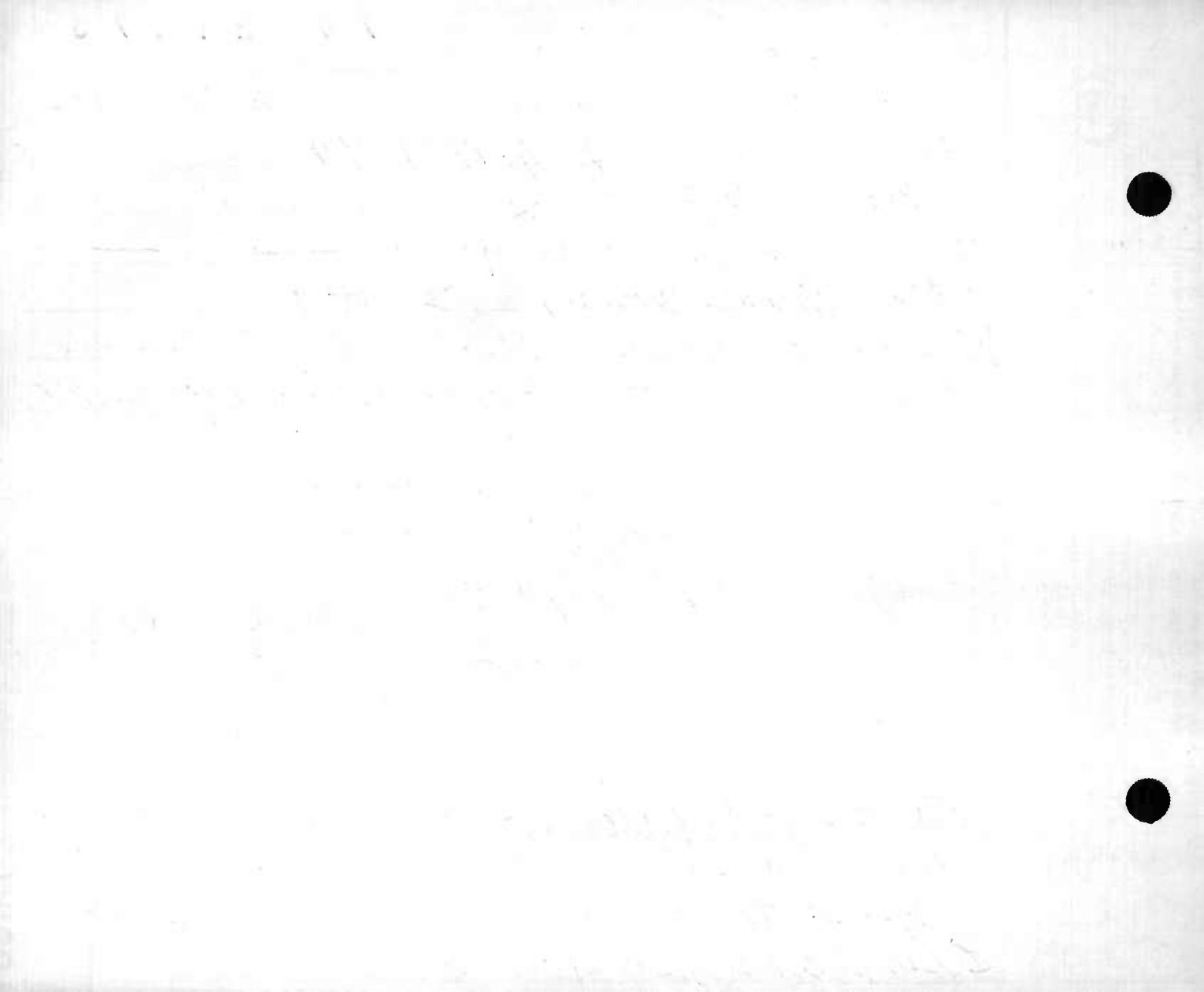


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 1 0 7 3		
1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Melissa M Furbush						08 18 79						1 <sup>10</sup> A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		4-4-1879		90		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Md		U. S.				Wicomico						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury			Wicomico Nursing Home									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
Md			Wicomico			Wetpawin			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. STREET ADDRESS						
William H. Dann			Mary C. Coulbourn			Rt 1						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
No			-			Esther Robertson, Tyiskin, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Decubitus ulcers</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Fracture of right hip</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE			22c. DATE SIGNED			
A.C. Mitchell						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			08-20-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
A.C. Mitchell						P.O. B 2378 Salisbury, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			8/24/79		Wetpawin Cem.			Wetpawin, Md				
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
C. H. Merritt, Biv 21ve, Md						AUG 24 1979			[Signature]			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21074

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) OLIVE LANCE GALBRAITH			2a. DATE OF DEATH MONTH DAY YEAR August 11, 1979			2b. HOUR 9 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 6, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 511 Tony Tank Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Wicomico Salisbury									
14. FATHER'S NAME FIRST MIDDLE LAST Joseph L. Lance					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May - Heger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Grant N. Galbraith, Same as 13c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Coronary Artery Disease</i> (c) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Summer</i> <i>10 yr</i> <i>15 yr</i>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>11/18</i> , 19 <i>79</i> , to <i>8/1</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>8/4/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.									
22b. SIGNATURE <i>J. B. Ruffe</i>				DEGREE		22c. DATE SIGNED 8/14/1979		22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. B. Ruffe	
22e. ADDRESS 215 Ohio Salisbury, MD				22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/14/1979		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Maryland			
24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds Funeral Home, Salisbury, Md.				25a. DATE RECEIVED BY REGISTRAR AUG 17 1979		25b. REGISTRAR'S SIGNATURE <i>John H. Brady</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 21075

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>J. RAYMOND</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>August 20, 1979</b>		2b. HOUR <b>2:25 A M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 23, 1911</b>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Captain</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fishing</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Somerset</b>		13c. CITY OR TOWN <b>Crisfield</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Guy W. Garrison</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>May Nelson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-01-6202</b>		17. INFORMANT ADDRESS <b>Mrs. Ida Mae Johns Same as 13 a,b,c,d,e</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma lung</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) _____ c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
--	--	---	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION <b>8-20-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca lung</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-16</b> , 19 <b>79</b> , to <b>8-20</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>8-20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							

22a. SIGNATURE <b>E. Kent Carney</b>		DEGREE <b>PHYSICIAN</b>		22c. DATE SIGNED <b>8-20-79</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. KENT CARNEY</b>		22e. ADDRESS <b>233 FLORIDIA AVE SALISBURY MD. 21801</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crisfield Somerset Md.</b>	
---	--	-----------------------------	--	--	--	---	--

24. FUNERAL DIRECTOR NAME <b>Bradshaw &amp; Sons</b>		ADDRESS <b>Crisfield, Md. 21817</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 24 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McBratney</b>	
--	--	--	--	---	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100000

(1000)

100-100000

100-100000 100-100000 100-100000

100-100000 100-100000 100-100000

100-100000 100-100000 100-100000

100-100000 100-100000 100-100000

100-100000 100-100000 100-100000

X

X

X

X

X

X

X

X

X

X

X

X

X

X

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 21076

1. DECEASED NAME (TYPE OR PRINT) <b>Rossie HARMON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 11, 1979</b>			2b. HOUR <b>12:10a</b>			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2/12/94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deer's Head Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>DOVERESTRE CAMBER</b>			13c. CITY OR TOWN <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES HARMON</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK.</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>212-16-1440</b>			17. INFORMANT <b>MAGGIE JONES</b>			ADDRESS <b>SAME</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERAL ARTERIOSCLEROSIS</b> (c) <b>DO TO, OR AS A CONSEQUENCE OF</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b> <b>SEVERAL YEARS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE. MULTIPLE DECUBITUS ULCERS</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>H. Wilberg MD</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8-11-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. H. Wilberg M.D.</b>						22e. ADDRESS <b>Deer's Head Center, Salisbury, Md. 21801</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>8/18/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. PLEASANT</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SOLEM DOG. MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Edwin C. St. Clair F. Home</b> <b>St. Clair F. Home</b> <b>Chamberlayne, MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCreary</b>	

BP

01012

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70 12-1-70 12-1-70 12-1-70 12-1-70 12-1-70 12-1-70 12-1-70 12-1-70 12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70 12-1-70 12-1-70 12-1-70 12-1-70 12-1-70 12-1-70 12-1-70 12-1-70 12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70

12-1-70



1. FOR STATE REGISTRAR  
 Film# G534 8/30/79  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

21077

1. DECEASED NAME (TYPE OR PRINT) <b>ATHALIA N. HARSELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 2 1979</b>			2b. HOUR <b>8:30</b> M			
3 SEX <b>F</b>		4 RACE <b>NEGRO</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>9 24 49</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>29</b> YRS			
7a. BIRTHPLACE (COUNTRY) <b>L. H. LAND, N. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.			
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
13a. STATE <b>N.J.</b>				13b. CITY OR TOWN <b>Middlesex Piscataway</b>		13c. STREET ADDRESS <b>147 Fisher Ave.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Lenwood Harrell</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY Harrison</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>139-44-6891</b>		17. INFORMANT ADDRESS <b>Wenwood Harrell (Add. SAME AS ABOVE)</b>			

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY <b>5308</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Upper gastric intestinal hernia</b>			
DUE TO, OR AS A CONSEQUENCE OF (b) <b>trauma esophagus fistula follow</b>		<b>5 wks</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Barium swallow follow Chaper for fracture of the identified</b>			

PART II. OTHER SIGNIFICANT CONDITIONS PREEXISTING AT DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION CAUSING DEATH  
**Cholecystitis due to chronic cholelithiasis**

19a. DATE OF OPERATION <b>6/28/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cholecystitis due to chronic cholelithiasis</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 16 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>fell 16 ft off</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>6-19</b> , 19 <b>79</b> , to <b>8-2</b> , 19 <b>79</b> , that (I) <del>the</del> last saw the deceased alive on <b>8/2</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							

21. SIGNATURE <b>Henry K Shoemaker</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/2/79</b>	
22. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry K Shoemaker</b>		22b. ADDRESS <b>Medical Center Salisbury Maryland</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-8-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Franklin Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>N. Brunswick-Middlesex N.J.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Jolley Memorial Chapel - Salisbury, Md</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry K Shoemaker</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11 2 1 1 1



11 2 1 1 1

11 2 1 1 1

11 2 1 1 1

11 2 1 1 1

11 2 1 1 1

11 2 1 1 1

11 2 1 1 1

11 2 1 1 1

11 2 1 1 1

11 2 1 1 1

11 2 1 1 1

11 2 1 1 1

11 2 1 1 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

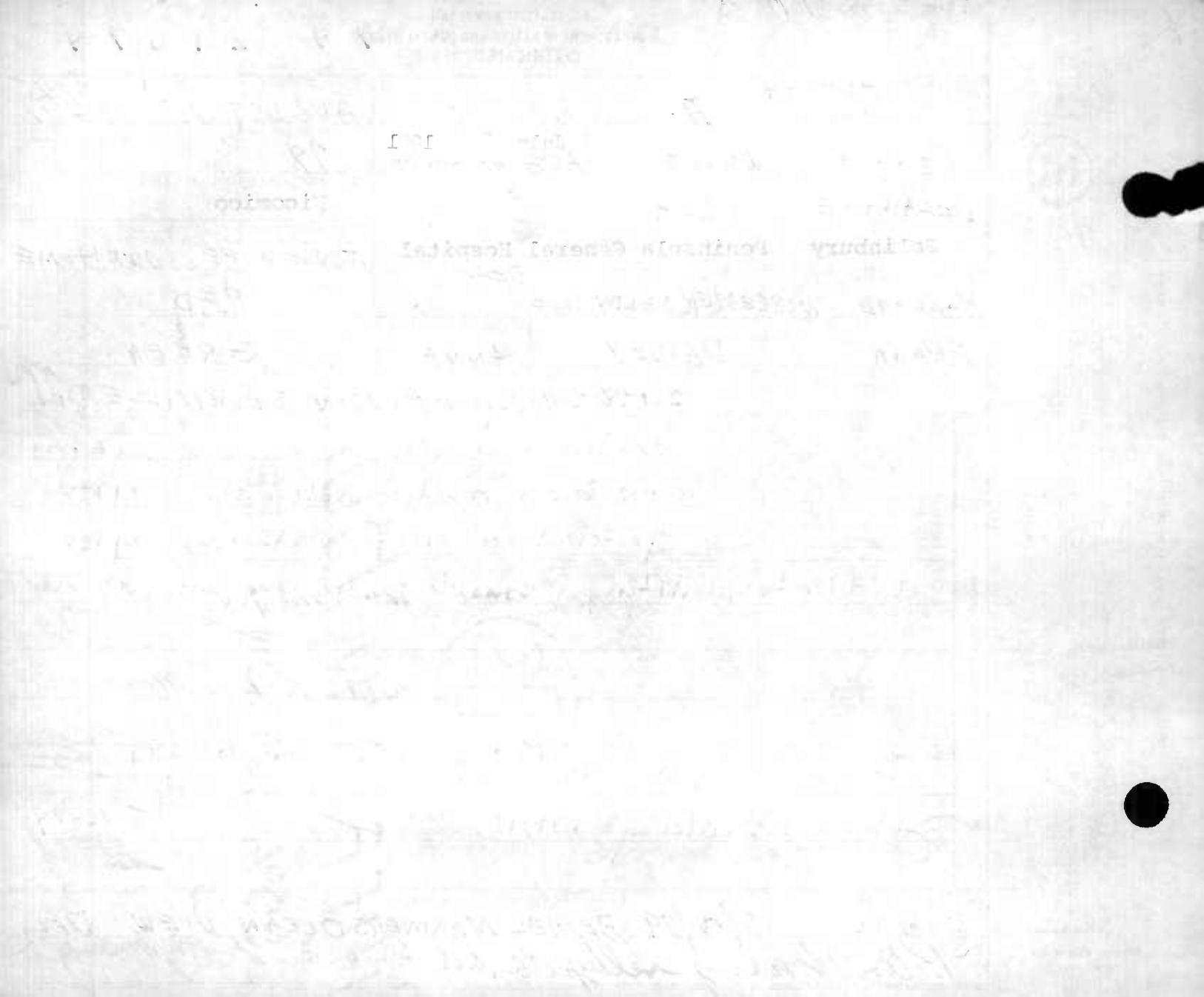
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR					REG. NO. 79 21078				
1 DECEASED NAME (TYPE OR PRINT) DOLLIE LAVENIA HASTINGS					2a DATE OF DEATH MONTH DAY YEAR Aug. 12, 1979			2b HOUR M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 25, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.			
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 403 Pinehurst Ave.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Wicomico 13c. CITY OR TOWN Salisbury					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 403 Pinehurst Ave.		
14 FATHER'S NAME FIRST MIDDLE LAST Merrell Morris					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary (unknown)				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 220-32-0792		17 INFORMANT (husband) ADDRESS Mr. W. Gorman Hastings same as 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular occlusion</u> 4349 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebrovascular arteriosclerosis</u> yrs (c) <u>Generalized arteriosclerosis</u> yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>April</u> 19 <u>77</u> , to <u>Aug</u> 19 <u>79</u> , that I (we) last saw the deceased alive on <u>July</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John T. Bulkeley</u> M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-14-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D.					22e. ADDRESS Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/15/79		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Md.			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.					25a. DATE RECD. BY REGISTRAR AUG 21 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>		







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 21080					
FOR 1. STATE REGISTRAR		FIRST MIDDLE LAST						2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
		ROLLIE P. HUDSON						AUGUST 20, 1979				10 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY) YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		FEB 19 1901				78							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		U.S.A.						Wicomico MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital								RET PAINTER				HOUSE	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
MARYLAND WORCESTER WILLIAMSVILLE												SEIBYVILLE DEL R.F.D.			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
JAMES EDW. HUDSON					MARY ISABELLE GRAY										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS					
					222-14-2738					PHYLLIS MEYER SALISBURY, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) 4409 Cardiac failure (Cerebral Hemiplegia) Day															
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis										year					
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
Diabetes Mellitus Myocardial infarction															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/16, 1979, to 8/20, 1979, that (I) (we) last saw the deceased alive on 8/20, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				22c. DATE SIGNED							
JOHN G. GREEN								8/20/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
JOHN G. GREEN				215 OHIO AVE. SALISBURY, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL				8-23-79		BETHEL MARINER				OCEAN VIEW SUSSEX DEL					
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Peter Whaley Seligman Sel.								AUG 27 1979							

BP

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535



NAME: JAMES E. HAYES  
BIRTH: 1911  
SEX: M  
RACE: W  
EDUCATION: HS  
OCCUPATION: N/A  
RESIDENCE: 1215 N. 1st St.,  
St. Louis, Mo.  
EMPLOYER: St. Louis  
STREET: 1215 N. 1st St.  
CITY: St. Louis  
STATE: Mo.  
ZIP: 63102

1. Name of subject: JAMES E. HAYES  
2. Date of birth: 1911  
3. Sex: M  
4. Race: W  
5. Education: HS  
6. Occupation: N/A  
7. Residence: 1215 N. 1st St.,  
St. Louis, Mo.  
8. Employer: St. Louis  
9. Street: 1215 N. 1st St.  
10. City: St. Louis  
11. State: Mo.  
12. ZIP: 63102

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. IF THE EXAMINER IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE EXECUTED BY THE REGISTRAR. IF THE EXAMINER IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE EXECUTED BY THE REGISTRAR. IF THE EXAMINER IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE EXECUTED BY THE REGISTRAR.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										21081 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert L. Jackson										2a. DATE OF DEATH KNOWN OF DEATH ESTIMATED 8 26 1979		2b. HOUR M	
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR July 4 1945		6 AGE (IN YEARS) LAST BIRTHDAY 34 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 8 26 1979		2d. HOUR 1:45 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD			
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINT. MAN				12b. KIND OF BUSINESS OR INDUSTRY HOTEL	
13a. STATE Maryland				13b. COUNTY Worcester		13c. CITY OR TOWN Ocean City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 505 Phila. Ave			
14. FATHER'S NAME FIRST MIDDLE LAST Robert B. Jackson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JUANITA Timmons									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 217-441817		17. INFORMANT ADDRESS Robert B. Jackson 906 Phila. Ave. Ocean City							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head (handgun)</u> 9550 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8-26-1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Light House Rd. & Ocean City, Worcester, Md. 139th St.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 8-28-79					
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (IFY) BURIAL				23b. DATE 8/31/79		23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Anna A. Burdge Berlin Md				25a. DATE REC'D. BY REGISTRAR SEP 6 1979				25b. REGISTRAR'S SIGNATURE <i>Thomas D. Smith</i>					

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 1/75  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. MONTH		4. DAY		5. YEAR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		3. MONTH		4. DAY		5. YEAR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 -		18b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18c. CITY OR TOWN		18d. STREET ADDRESS	
18b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18c. CITY OR TOWN		18d. STREET ADDRESS		18e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18c. CITY OR TOWN		18d. STREET ADDRESS		18e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18f. CITY OR TOWN		18g. STREET ADDRESS	
18d. STREET ADDRESS		18e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18f. CITY OR TOWN		18g. STREET ADDRESS		18h. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18f. CITY OR TOWN		18g. STREET ADDRESS		18h. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18i. CITY OR TOWN	
18f. CITY OR TOWN		18g. STREET ADDRESS		18h. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18i. CITY OR TOWN		18j. STREET ADDRESS	
18g. STREET ADDRESS		18h. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18i. CITY OR TOWN		18j. STREET ADDRESS		18k. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18h. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18i. CITY OR TOWN		18j. STREET ADDRESS		18k. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18l. CITY OR TOWN	
18i. CITY OR TOWN		18j. STREET ADDRESS		18k. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18l. CITY OR TOWN		18m. STREET ADDRESS	
18j. STREET ADDRESS		18k. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18l. CITY OR TOWN		18m. STREET ADDRESS		18n. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18k. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18l. CITY OR TOWN		18m. STREET ADDRESS		18n. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18o. CITY OR TOWN	
18l. CITY OR TOWN		18m. STREET ADDRESS		18n. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18o. CITY OR TOWN		18p. STREET ADDRESS	
18m. STREET ADDRESS		18n. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18o. CITY OR TOWN		18p. STREET ADDRESS		18q. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18n. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18o. CITY OR TOWN		18p. STREET ADDRESS		18q. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18r. CITY OR TOWN	
18o. CITY OR TOWN		18p. STREET ADDRESS		18q. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18r. CITY OR TOWN		18s. STREET ADDRESS	
18p. STREET ADDRESS		18q. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18r. CITY OR TOWN		18s. STREET ADDRESS		18t. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18q. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18r. CITY OR TOWN		18s. STREET ADDRESS		18t. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18u. CITY OR TOWN	
18r. CITY OR TOWN		18s. STREET ADDRESS		18t. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18u. CITY OR TOWN		18v. STREET ADDRESS	
18s. STREET ADDRESS		18t. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18u. CITY OR TOWN		18v. STREET ADDRESS		18w. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18t. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18u. CITY OR TOWN		18v. STREET ADDRESS		18w. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18x. CITY OR TOWN	
18u. CITY OR TOWN		18v. STREET ADDRESS		18w. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18x. CITY OR TOWN		18y. STREET ADDRESS	
18v. STREET ADDRESS		18w. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18x. CITY OR TOWN		18y. STREET ADDRESS		18z. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18w. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18x. CITY OR TOWN		18y. STREET ADDRESS		18z. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION	
18x. CITY OR TOWN		18y. STREET ADDRESS		18z. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
18y. STREET ADDRESS		18z. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?	
18z. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY	
19c. AUTOPSY?		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20d. INJURY OCCURRED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20d. INJURY OCCURRED		20e. PLACE OF INJURY	
20b. TIME OF INJURY		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20d. INJURY OCCURRED		20e. PLACE OF INJURY		20f. LOCATION	
20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20d. INJURY OCCURRED		20e. PLACE OF INJURY		20f. LOCATION		20g. CITY OR TOWN	
20d. INJURY OCCURRED		20e. PLACE OF INJURY		20f. LOCATION		20g. CITY OR TOWN		20h. COUNTY	
20e. PLACE OF INJURY		20f. LOCATION		20g. CITY OR TOWN		20h. COUNTY		20i. STATE	
20f. LOCATION		20g. CITY OR TOWN		20h. COUNTY		20i. STATE		20j. I certify that (I) (this hospital) attended the deceased from	
20g. CITY OR TOWN		20h. COUNTY		20i. STATE		20j. I certify that (I) (this hospital) attended the deceased from		20k. saw the deceased alive on	
20h. COUNTY		20i. STATE		20j. I certify that (I) (this hospital) attended the deceased from		20k. saw the deceased alive on		20l. above, (I) (we) (d) (did not) view the body after death.	
20i. STATE		20j. I certify that (I) (this hospital) attended the deceased from		20k. saw the deceased alive on		20l. above, (I) (we) (d) (did not) view the body after death.		20m. SIGNATURE	
20j. I certify that (I) (this hospital) attended the deceased from		20k. saw the deceased alive on		20l. above, (I) (we) (d) (did not) view the body after death.		20m. SIGNATURE		20n. DEGREE	
20k. saw the deceased alive on		20l. above, (I) (we) (d) (did not) view the body after death.		20m. SIGNATURE		20n. DEGREE		20o. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
20l. above, (I) (we) (d) (did not) view the body after death.		20m. SIGNATURE		20n. DEGREE		20o. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		20p. DATE SIGNED	
20m. SIGNATURE		20n. DEGREE		20o. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		20p. DATE SIGNED		20q. PHYSICIAN'S NAME (TYPE OR PRINT)	
20n. DEGREE		20o. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		20p. DATE SIGNED		20q. PHYSICIAN'S NAME (TYPE OR PRINT)		20r. ADDRESS	
20o. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		20p. DATE SIGNED		20q. PHYSICIAN'S NAME (TYPE OR PRINT)		20r. ADDRESS		20s. BURIAL, CREMATION, REMOVAL (SPECIFY)	
20p. DATE SIGNED		20q. PHYSICIAN'S NAME (TYPE OR PRINT)		20r. ADDRESS		20s. BURIAL, CREMATION, REMOVAL (SPECIFY)		20t. DATE	
20q. PHYSICIAN'S NAME (TYPE OR PRINT)		20r. ADDRESS		20s. BURIAL, CREMATION, REMOVAL (SPECIFY)		20t. DATE		20u. NAME OF CEMETERY OR CREMATORY	
20r. ADDRESS		20s. BURIAL, CREMATION, REMOVAL (SPECIFY)		20t. DATE		20u. NAME OF CEMETERY OR CREMATORY		20v. LOCATION	
20s. BURIAL, CREMATION, REMOVAL (SPECIFY)		20t. DATE		20u. NAME OF CEMETERY OR CREMATORY		20v. LOCATION		20w. CITY OR TOWN	
20t. DATE		20u. NAME OF CEMETERY OR CREMATORY		20v. LOCATION		20w. CITY OR TOWN		20x. COUNTY	
20u. NAME OF CEMETERY OR CREMATORY		20v. LOCATION		20w. CITY OR TOWN		20x. COUNTY		20y. STATE	
20v. LOCATION		20w. CITY OR TOWN		20x. COUNTY		20y. STATE		20z. FUNERAL DIRECTOR	
20w. CITY OR TOWN		20x. COUNTY		20y. STATE		20z. FUNERAL DIRECTOR		20aa. DATE REC'D. BY REGISTRAR	
20x. COUNTY		20y. STATE		20z. FUNERAL DIRECTOR		20aa. DATE REC'D. BY REGISTRAR		20ab. REGISTRAR'S SIGNATURE	
20y. STATE		20z. FUNERAL DIRECTOR		20aa. DATE REC'D. BY REGISTRAR		20ab. REGISTRAR'S SIGNATURE		20ac. DATE REC'D. BY REGISTRAR	
20z. FUNERAL DIRECTOR		20aa. DATE REC'D. BY REGISTRAR		20ab. REGISTRAR'S SIGNATURE		20ac. DATE REC'D. BY REGISTRAR		20ad. REGISTRAR'S SIGNATURE	
20aa. DATE REC'D. BY REGISTRAR		20ab. REGISTRAR'S SIGNATURE		20ac. DATE REC'D. BY REGISTRAR		20ad. REGISTRAR'S SIGNATURE		20ae. DATE REC'D. BY REGISTRAR	
20ab. REGISTRAR'S SIGNATURE		20ac. DATE REC'D. BY REGISTRAR		20ad. REGISTRAR'S SIGNATURE		20ae. DATE REC'D. BY REGISTRAR		20af. REGISTRAR'S SIGNATURE	
20ac. DATE REC'D. BY REGISTRAR		20ad. REGISTRAR'S SIGNATURE		20ae. DATE REC'D. BY REGISTRAR		20af. REGISTRAR'S SIGNATURE		20ag. DATE REC'D. BY REGISTRAR	
20ad. REGISTRAR'S SIGNATURE		20ae. DATE REC'D. BY REGISTRAR		20af. REGISTRAR'S SIGNATURE		20ag. DATE REC'D. BY REGISTRAR		20ah. REGISTRAR'S SIGNATURE	
20ae. DATE REC'D. BY REGISTRAR		20af. REGISTRAR'S SIGNATURE		20ag. DATE REC'D. BY REGISTRAR		20ah. REGISTRAR'S SIGNATURE		20ai. DATE REC'D. BY REGISTRAR	
20af. REGISTRAR'S SIGNATURE		20ag. DATE REC'D. BY REGISTRAR		20ah. REGISTRAR'S SIGNATURE		20ai. DATE REC'D. BY REGISTRAR		20aj. REGISTRAR'S SIGNATURE	
20ag. DATE REC'D. BY REGISTRAR		20ah. REGISTRAR'S SIGNATURE		20ai. DATE REC'D. BY REGISTRAR		20aj. REGISTRAR'S SIGNATURE		20ak. DATE REC'D. BY REGISTRAR	
20ah. REGISTRAR'S SIGNATURE		20ai. DATE REC'D. BY REGISTRAR		20aj. REGISTRAR'S SIGNATURE		20ak. DATE REC'D. BY REGISTRAR		20al. REGISTRAR'S SIGNATURE	
20ai. DATE REC'D. BY REGISTRAR		20aj. REGISTRAR'S SIGNATURE		20ak. DATE REC'D. BY REGISTRAR		20al. REGISTRAR'S SIGNATURE		20am. DATE REC'D. BY REGISTRAR	
20aj. REGISTRAR'S SIGNATURE		20ak. DATE REC'D. BY REGISTRAR		20al. REGISTRAR'S SIGNATURE		20am. DATE REC'D. BY REGISTRAR		20an. REGISTRAR'S SIGNATURE	
20ak. DATE REC'D. BY REGISTRAR		20al. REGISTRAR'S SIGNATURE		20am. DATE REC'D. BY REGISTRAR		20an. REGISTRAR'S SIGNATURE		20ao. DATE REC'D. BY REGISTRAR	
20al. REGISTRAR'S SIGNATURE		20am. DATE REC'D. BY REGISTRAR		20an. REGISTRAR'S SIGNATURE		20ao. DATE REC'D. BY REGISTRAR		20ap. REGISTRAR'S SIGNATURE	
20am. DATE REC'D. BY REGISTRAR		20an. REGISTRAR'S SIGNATURE		20ao. DATE REC'D. BY REGISTRAR		20ap. REGISTRAR'S SIGNATURE		20aq. DATE REC'D. BY REGISTRAR	
20an. REGISTRAR'S SIGNATURE		20ao. DATE REC'D. BY REGISTRAR		20ap. REGISTRAR'S SIGNATURE		20aq. DATE REC'D. BY REGISTRAR		20ar. REGISTRAR'S SIGNATURE	
20ao. DATE REC'D. BY REGISTRAR		20ap. REGISTRAR'S SIGNATURE		20aq. DATE REC'D. BY REGISTRAR		20ar. REGISTRAR'S SIGNATURE		20as. DATE REC'D. BY REGISTRAR	
20ap. REGISTRAR'S SIGNATURE		20aq. DATE REC'D. BY REGISTRAR		20ar. REGISTRAR'S SIGNATURE		20as. DATE REC'D. BY REGISTRAR		20at. REGISTRAR'S SIGNATURE	
20aq. DATE REC'D. BY REGISTRAR		20ar. REGISTRAR'S SIGNATURE		20as. DATE REC'D. BY REGISTRAR		20at. REGISTRAR'S SIGNATURE		20au. DATE REC'D. BY REGISTRAR	
20ar. REGISTRAR'S SIGNATURE		20as. DATE REC'D. BY REGISTRAR		20at. REGISTRAR'S SIGNATURE		20au. DATE REC'D. BY REGISTRAR		20av. REGISTRAR'S SIGNATURE	
20as. DATE REC'D. BY REGISTRAR		20at. REGISTRAR'S SIGNATURE		20au. DATE REC'D. BY REGISTRAR		20av. REGISTRAR'S SIGNATURE		20aw. DATE REC'D. BY REGISTRAR	
20at. REGISTRAR'S SIGNATURE		20au. DATE REC'D. BY REGISTRAR		20av. REGISTRAR'S SIGNATURE		20aw. DATE REC'D. BY REGISTRAR		20ax. REGISTRAR'S SIGNATURE	
20au. DATE REC'D. BY REGISTRAR		20av. REGISTRAR'S SIGNATURE		20aw. DATE REC'D. BY REGISTRAR		20ax. REGISTRAR'S SIGNATURE		20ay. DATE REC'D. BY REGISTRAR	
20av. REGISTRAR'S SIGNATURE		20aw. DATE REC'D. BY REGISTRAR		20ax. REGISTRAR'S SIGNATURE		20ay. DATE REC'D. BY REGISTRAR		20az. REGISTRAR'S SIGNATURE	
20aw. DATE REC'D. BY REGISTRAR		20ax. REGISTRAR'S SIGNATURE		20ay. DATE REC'D. BY REGISTRAR		20az. REGISTRAR'S SIGNATURE		20ba. DATE REC'D. BY REGISTRAR	
20ax. REGISTRAR'S SIGNATURE		20ay. DATE REC'D. BY REGISTRAR		20az. REGISTRAR'S SIGNATURE		20ba. DATE REC'D. BY REGISTRAR		20bb. REGISTRAR'S SIGNATURE	
20ay. DATE REC'D. BY REGISTRAR		20az. REGISTRAR'S SIGNATURE		20ba. DATE REC'D. BY REGISTRAR		20bb. REGISTRAR'S SIGNATURE		20bc. DATE REC'D. BY REGISTRAR	
20az. REGISTRAR'S SIGNATURE		20ba. DATE REC'D. BY REGISTRAR		20bb. REGISTRAR'S SIGNATURE		20bc. DATE REC'D. BY REGISTRAR		20bd. REGISTRAR'S SIGNATURE	
20ba. DATE REC'D. BY REGISTRAR		20bb. REGISTRAR'S SIGNATURE		20bc. DATE REC'D. BY REGISTRAR		20bd. REGISTRAR'S SIGNATURE		20be. DATE REC'D. BY REGISTRAR	
20bb. REGISTRAR'S SIGNATURE		20bc. DATE REC'D. BY REGISTRAR		20bd. REGISTRAR'S SIGNATURE		20be. DATE REC'D. BY REGISTRAR		20bf. REGISTRAR'S SIGNATURE	
20bc. DATE REC'D. BY REGISTRAR		20bd. REGISTRAR'S SIGNATURE		20be. DATE REC'D. BY REGISTRAR		20bf. REGISTRAR'S SIGNATURE		20bg. DATE REC'D. BY REGISTRAR	
20bd. REGISTRAR'S SIGNATURE		20be. DATE REC'D. BY REGISTRAR		20bf. REGISTRAR'S SIGNATURE		20bg. DATE REC'D. BY REGISTRAR		20bh. REGISTRAR'S SIGNATURE	
20be. DATE REC'D. BY REGISTRAR		20bf. REGISTRAR'S SIGNATURE		20bg. DATE REC'D. BY REGISTRAR		20bh. REGISTRAR'S SIGNATURE		20bi. DATE REC'D. BY REGISTRAR	
20bf. REGISTRAR'S SIGNATURE		20bg. DATE REC'D. BY REGISTRAR		20bh. REGISTRAR'S SIGNATURE		20bi. DATE REC'D. BY REGISTRAR		20bj. REGISTRAR'S SIGNATURE	
20bg. DATE REC'D. BY REGISTRAR		20bh. REGISTRAR'S SIGNATURE		20bi. DATE REC'D. BY REGISTRAR		20bj. REGISTRAR'S SIGNATURE		20bk. DATE REC'D. BY REGISTRAR	
20bh. REGISTRAR'S SIGNATURE		20bi. DATE REC'D. BY REGISTRAR		20bj. REGISTRAR'S SIGNATURE		20bk. DATE REC'D. BY REGISTRAR		20bl. REGISTRAR'S SIGNATURE	
20bi. DATE REC'D. BY REGISTRAR		20bj. REGISTRAR'S SIGNATURE		20bk. DATE REC'D. BY REGISTRAR		20bl. REGISTRAR'S SIGNATURE		20bm. DATE REC'D. BY REGISTRAR	
20bj. REGISTRAR'S SIGNATURE		20bk. DATE REC'D. BY REGISTRAR		20bl. REGISTRAR'S SIGNATURE		20bm. DATE REC'D. BY REGISTRAR		20bn. REGISTRAR'S SIGNATURE	
20bk. DATE REC'D. BY REGISTRAR		20bl. REGISTRAR'S SIGNATURE		20bm. DATE REC'D. BY REGISTRAR		20bn. REGISTRAR'S SIGNATURE		20bo. DATE REC'D. BY REGISTRAR	
20bl. REGISTRAR'S SIGNATURE		20bm. DATE REC'D. BY REGISTRAR		20bn. REGISTRAR'S SIGNATURE		20bo. DATE REC'D. BY REGISTRAR		20bp. REGISTRAR'S SIGNATURE	
20bm. DATE REC'D. BY REGISTRAR		20bn. REGISTRAR'S SIGNATURE		20bo. DATE REC'D. BY REGISTRAR		20bp. REGISTRAR'S SIGNATURE		20bq. DATE REC'D. BY REGISTRAR	
20bn. REGISTRAR'S SIGNATURE		20bo. DATE REC'D. BY REGISTRAR		20bp. REGISTRAR'S SIGNATURE		20bq. DATE REC'D. BY REGISTRAR		20br. REGISTRAR'S SIGNATURE	
20bo. DATE REC'D. BY REGISTRAR		20bp. REGISTRAR'S SIGNATURE		20bq. DATE REC'D. BY REGISTRAR		20br. REGISTRAR'S SIGNATURE		20bs. DATE REC'D. BY REGISTRAR	
20bp. REGISTRAR'S SIGNATURE		20bq. DATE REC'D. BY REGISTRAR		20br. REGISTRAR'S SIGNATURE		20bs. DATE REC'D. BY REGISTRAR		20bt. REGISTRAR'S SIGNATURE	
20bq. DATE REC'D. BY REGISTRAR		20br. REGISTRAR'S SIGNATURE		20bs. DATE REC'D. BY REGISTRAR		20bt. REGISTRAR'S SIGNATURE		20bu. DATE REC'D. BY REGISTRAR	
20br. REGISTRAR'S SIGNATURE		20bs. DATE REC'D. BY REGISTRAR		20bt. REGISTRAR'S SIGNATURE		20bu. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE	
20bs. DATE REC'D. BY REGISTRAR		20bt. REGISTRAR'S SIGNATURE		20bu. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR	
20bt. REGISTRAR'S SIGNATURE		20bu. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE	
20bu. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR	
20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE	
20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR	
20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE	
20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR	
20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGNATURE		20bv. DATE REC'D. BY REGISTRAR		20bv. REGISTRAR'S SIGN	

100-11101



Wisconsin

Peninsula General Hospital

Salisbury

Dear Sirs:

I am writing to you regarding the matter of the Peninsula General Hospital. I have been informed that you are interested in the hospital and its operations. I am pleased to hear of your interest and would like to provide you with some information.

The Peninsula General Hospital is a large, modern hospital with a long history of service to the community. It is a non-profit organization and is dedicated to providing the highest quality of care to our patients. We have a staff of highly qualified medical professionals and a state-of-the-art facility.

I am sure that you will find our hospital to be a valuable asset to your community. We would be happy to discuss our hospital further and answer any questions you may have.

Sincerely,

[Signature]

Very truly yours,

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 11 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79 21083					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary S. JENNINGS										AUGUST 9, 1979				12 <sup>15</sup> PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
female		white		May 12, 1911			68 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		USA					Wicomico MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital								Gov't Emp. -		NASA			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. CITY OR TOWN		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS							
13a. STATE				Accomac		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		H-15							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
William Henry Schoolfield				Amy S. Blaine											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no				113-18-4142		Alice J. Tarr		50 Strayhorn Lane Elkton, Md. 21921							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory Arrest</u> 2869 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intracranial Haemorrhage</u> (c) <u>Anticoagulation</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pulmonary Embolism, metastatic carcinoma - Pathological</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
		P.M. 19													
21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7.27. 1979 to 8.9. 1979, that (I) (we) last saw the deceased alive on 8.9. 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED					
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				8/9/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
D. SAGGAR		547 Riverside Drive Suite E Salisbury													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		8/11/79		Salem Meth. Cem.		Pocomoke		Worcester		Md.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Scott S. Melan Pocomoke City, Md.						AUG 14 1979		Kirsty McCreedy							

MEDICAL CERTIFICATION

BP

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 21084

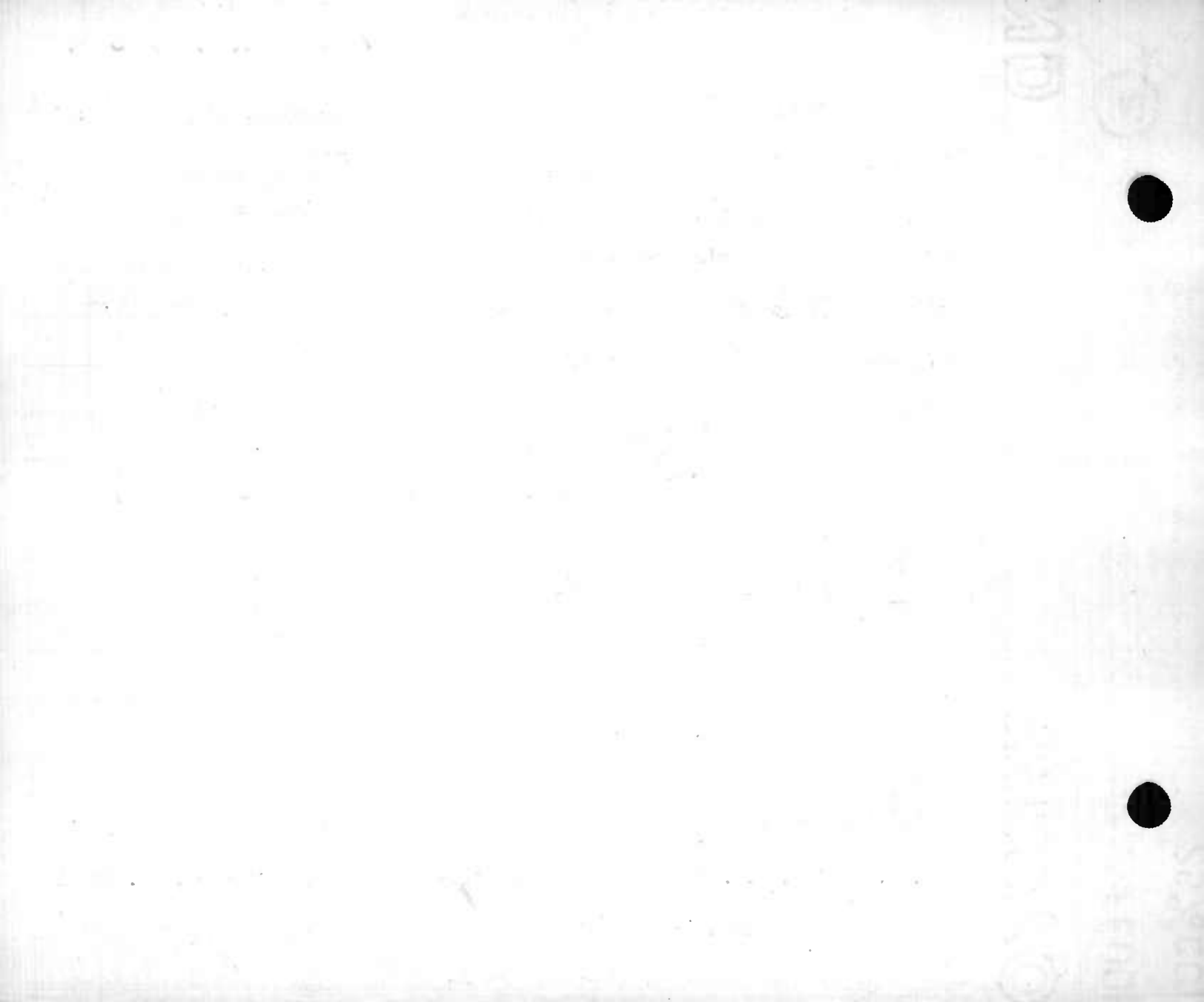
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
Elsie		JOHNSON						August 5, 1979					7:30 A	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		Negro		12 20 90		88		MONTHS		DAYS		HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH								
Md		USA				Wi comi co						MD.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY								
Salisbury		Deer's Head Center		Domestic										
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS						
Md		Talle		Eastern		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		South St						
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME												
Charles		Brennell		Ella		Dickerson								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS								
2		217-30-8218		Freda		Jennings								
18 CAUSE OF DEATH (Enter only one cause per the format, (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Peripartur vasc. disease DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
4292		Peripartur vasc. disease												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		Pneumonia												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I did) (I did not) view the body after death.		22b SIGNATURE Walden		DEGREE		22c DATE SIGNED 8/5/79								
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										
L. V. Maldve, M.D.		Deer's Head Center, Salisbury, Md. 21801												
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY		STATE				
8/9/79		8/9/79		Paradise		Troppe		TA		MD				
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE								
George H. Dorschner		Deer's Head Center		AUG 17 1979		L. V. Maldve								

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

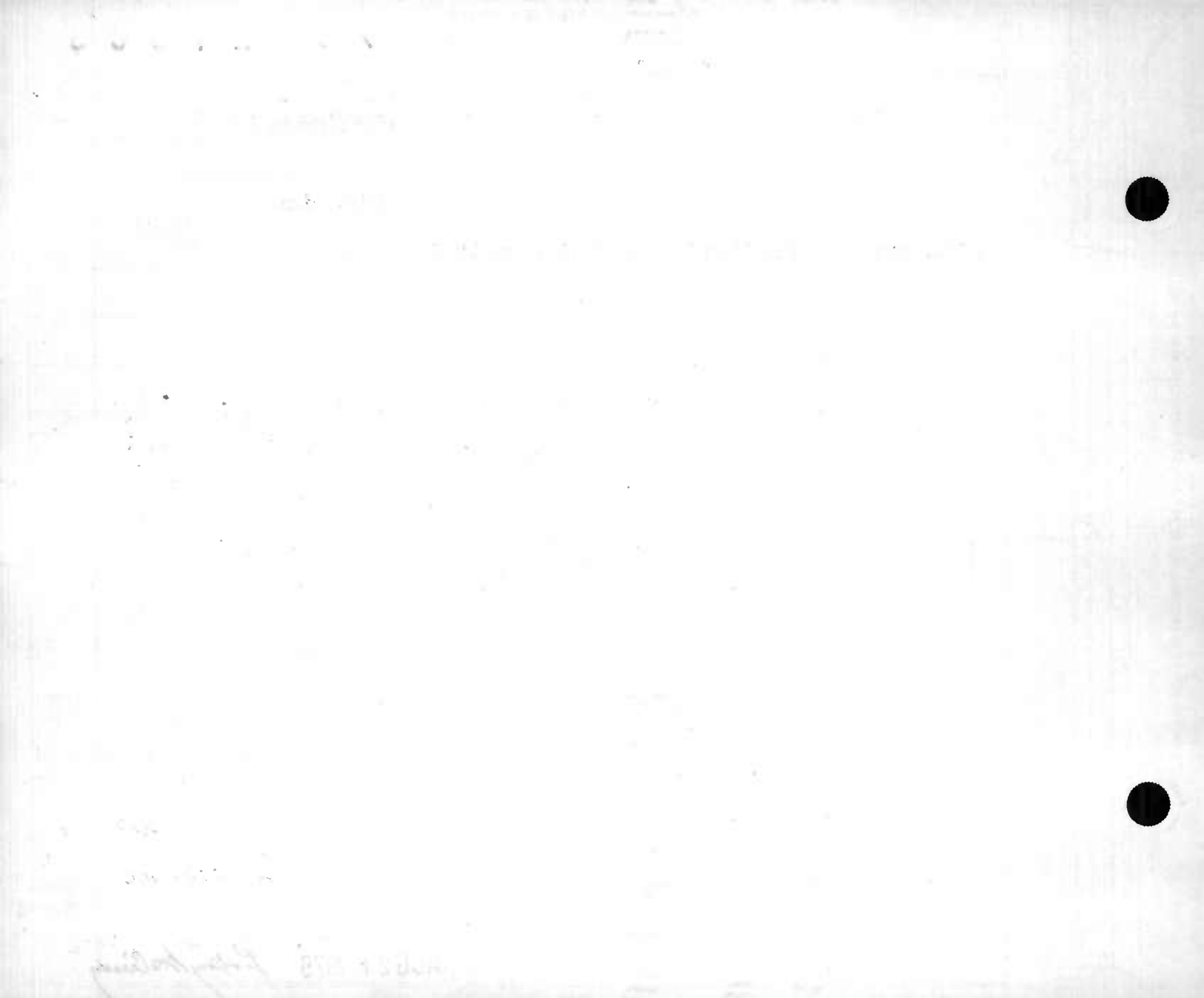


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 21085	
1. DECEASED NAME (TYPE OR PRINT) WILBER BENSON Johnson					2a. DATE OF DEATH MONTH DAY YEAR August 22, 1979			2b. HOUR 5:36 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Hampton, Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		12b. KIND OF BUSINESS OR INDUSTRY Construction			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 301 E. Carroll Street			
14. FATHER'S NAME FIRST MIDDLE LAST James Edward Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Spence						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-16-7403		17. INFORMANT ADDRESS (wife) Mrs. Daisie C. Johnson same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident due to</u> <u>436-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced cerebral atherosclerosis &amp; chronic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Heart Failure with atrial fibrillation</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>chronic obstructive Pulmonary disease with chronic Respiratory failure</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>75</u> , to <u>8/22</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8/22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Joseph Z. Badros, M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 8-23-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH Z. BADROS						22e. ADDRESS 229 FLORIDA AVE SALISBURY, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/24/79		23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.						25a. DATE REC'D. BY REGISTRAR AUG 28 1979		25b. REGISTRAR'S SIGNATURE <u>Henry M. Brady</u>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CARDNER LEONARD Jones</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>August 7, 1979</b>		2b. HOUR <b>1:55 AM</b>	
3 SEX <b>male</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>12 5 15</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Fruitland, Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.			
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>hospital</b>	
13a. STATE <b>Md</b> 13b. COUNTY <b>Wicomico</b> 13c. CITY OR TOWN <b>Fruitland</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>102 BROADWAY ST</b>									
14 FATHER'S NAME FIRST MIDDLE LAST <b>Robert Fred Jones</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Emmet Menefee</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>					16b. SOCIAL SECURITY NO. <b>218-01-4326</b>		17 INFORMANT ADDRESS <b>McLVERTA Thomas</b> <b>SAME as above</b>		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Liver failure</b> <b>5728</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>5 Aug</b> , 19 <b>79</b> , to <b>7 Aug</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6 Aug 79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>ET Gwell</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>7 Aug 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Colwell</b>					22e. ADDRESS <b>P &amp; A Salisbury Md</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>8-11-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fruitland Wicomico Md</b>		
24 FUNERAL DIRECTOR NAME <b>Valley Funeral Home</b>					ADDRESS <b>P.O. #2 Jersey Rd Salisbury, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1979</b>		

BP

1945

1945

California General Hospital

1945



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

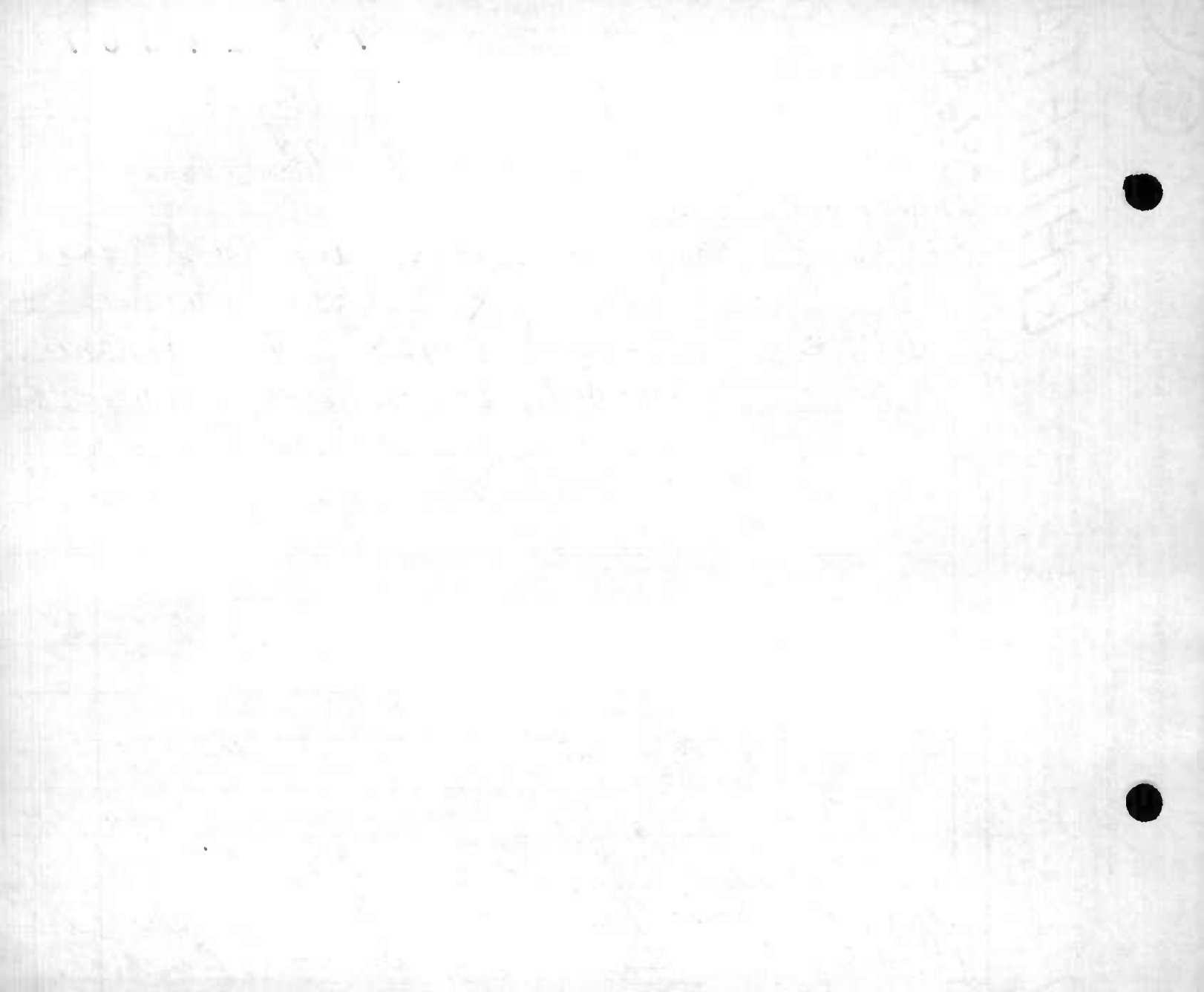
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79 21087  
REG. NO.1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Sadie Jones</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Aug 14 79</b>		2b. HOUR <b>7a</b>
3 SEX <b>Female</b>	4 RACE <b>C NEGRO</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>3 22 07</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico Co.</b> MD.	
10 CITY OR TOWN OF DEATH <b>SALISBURY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>330 CATHERINE ST</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LAST YEAR) <b>Campbell Soup</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>WICOMICO</b> 13c. CITY OR TOWN <b>SALIS.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>330 CATHERINE ST</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Willie James</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMILY V PARSONS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-14-1899</b>		17 INFORMANT <b>WALTER Jones, Baltimore, MD</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Endophthalmitis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>9 9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7 Aug</b> 19 <b>79</b> to <b>14 Aug</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>14 Aug</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Therrell M</b>		DEGREE		22c. DATE SIGNED <b>15 Aug 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. H. Furnell, M.D.</b>		22e. ADDRESS <b>65 E. W. MAIN ST Salisbury Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>8-18-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Memorial</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salis. Wic. Md</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>West-Forks Salis. Md</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 17 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Robert K. B...</b>	





83

00

35

22

1

1

3

2

BP

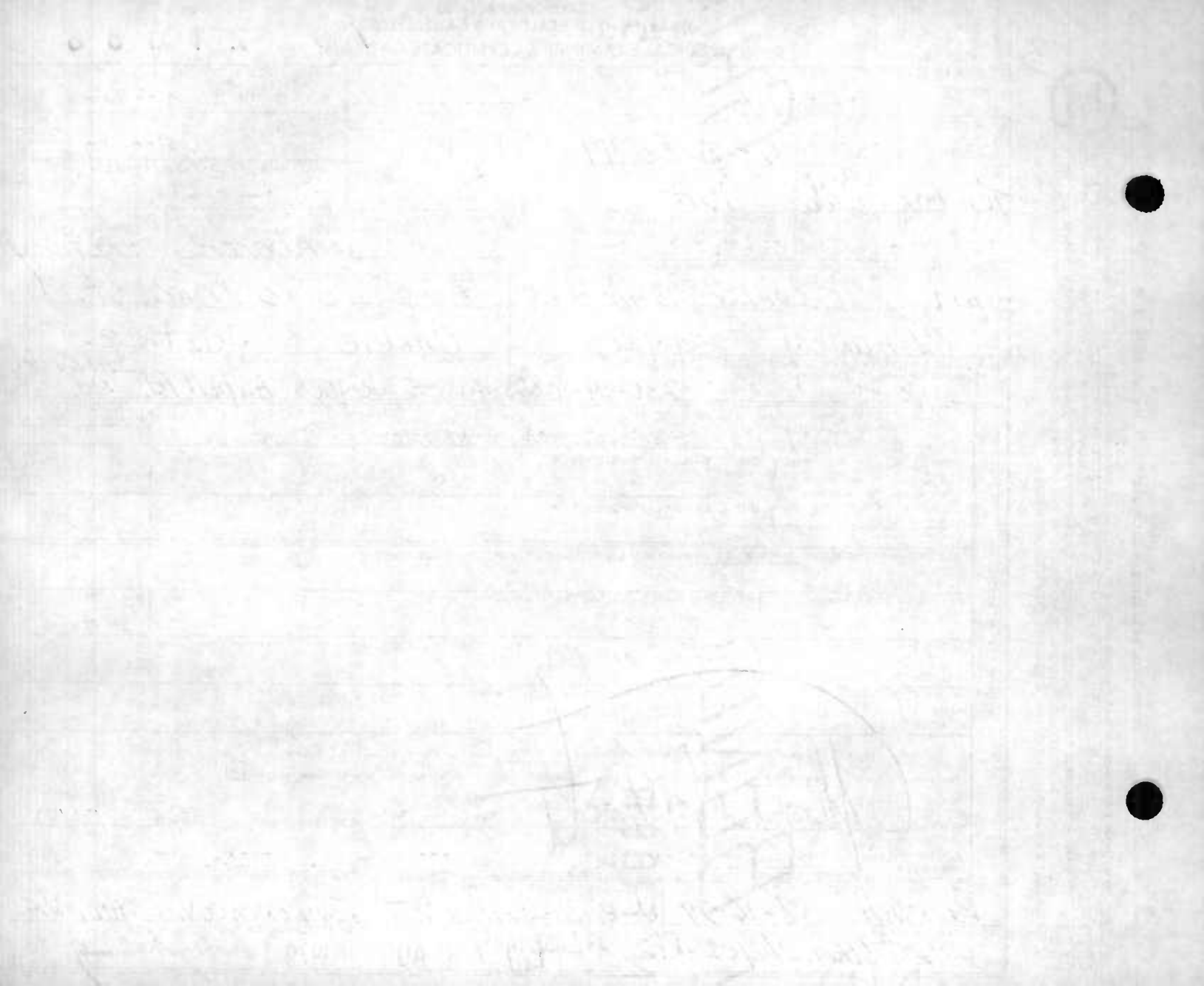
DHMH - 17  
(VR A15 ME (5))  
15M7/761- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21088

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Randolph			8 11 1979			M		
3. SEX			4. RACE			5. DATE OF BIRTH		
Male			Black			6-8-30 49 YRS.		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
Va. Temperanceville			USA			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Salisbury			510 W. Main Street			Laborer Factory		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Md.			Wicomico			Salisbury		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE YEAR OR DATES)		
Chauncy			Carrie Justice			No. 1		
16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
230-34-7082			JAMES JOYNES			Airport Rd. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
			P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Thomas D. Smith			Deputy Chief			8/14/79		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Thomas D. Smith, M.D.			111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
BURIAL			8-16-79			Jerusalem Baptist		
24. FUNERAL DIRECTOR (NAME)			ADDRESS			25a. DATE REC'D. BY REGISTRAR		
Jolley Mem. Chapel			Rt 2, Salisbury Md.			AUG 20 1979		
						25b. REGISTRAR'S SIGNATURE		
						[Signature]		

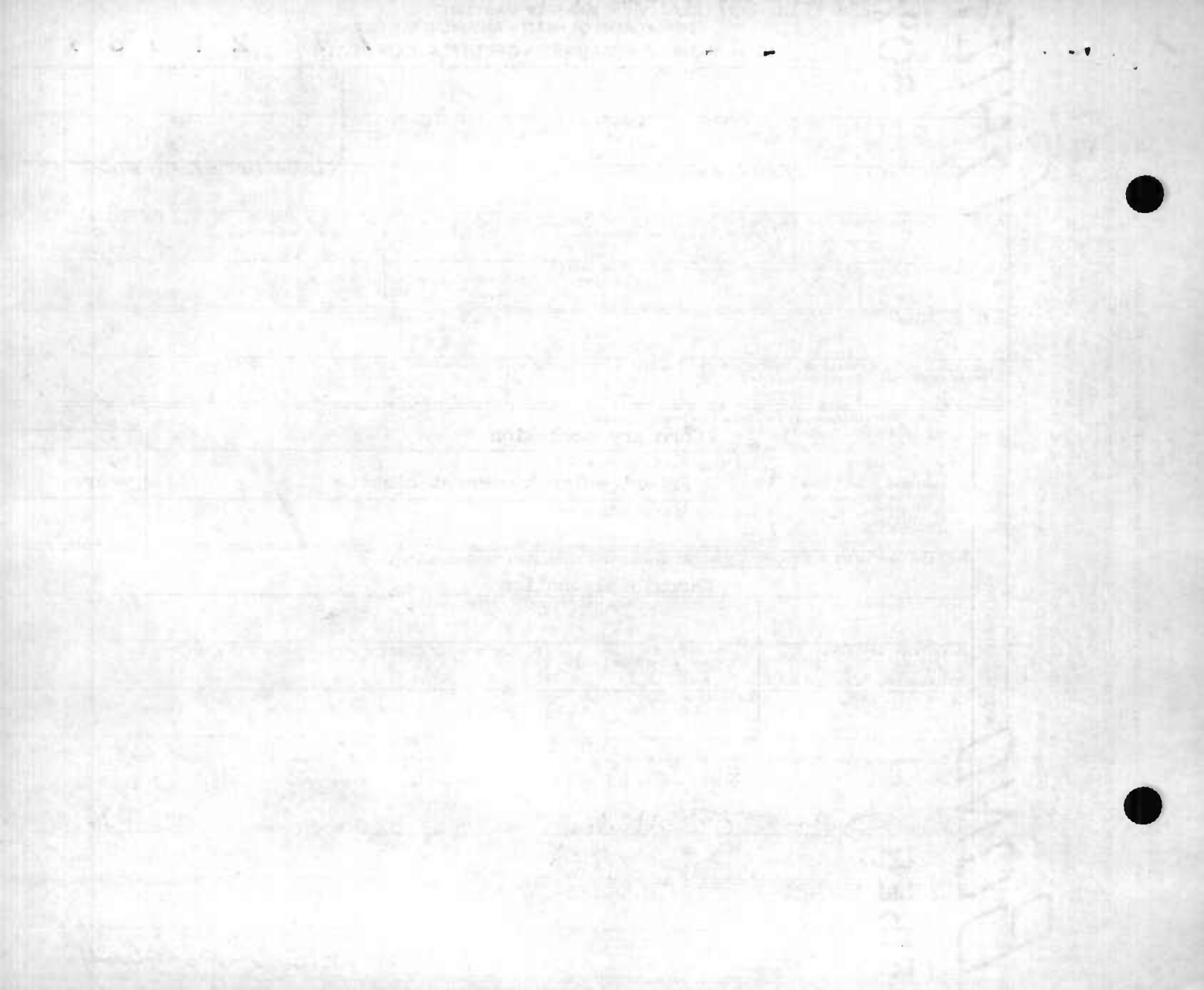
BP

DHMH - 17  
(VR A15 ME (5))  
15M7/76



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3". RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21089	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL BOLTON KELLEY										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 19 <input type="checkbox"/> M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 24, 27	6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) unknown	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Aug. 19 19 79	9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD		2d. HOUR M	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 300 Newton Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY House painter			
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 300 Newton Street			
14. FATHER'S NAME FIRST MIDDLE LAST William Richard Kelley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Virginia Griffin				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 215-26-1861	
17. INFORMANT (niece) Mrs. Norma L. Harris, Delmar, Md.				17. ADDRESS 202 Chestnut St.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 410 - IMMEDIATE CAUSE (a) Coronary occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b) Arteriosclerotic Heart disease				(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Chronic alcoholism											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John T. Bulkeley				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 8/26/79			
EXAMINER'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D.				ADDRESS Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/27/79		23c. NAME OF CEMETERY OR CREMATORY Wango Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wango, Wicomico, Maryland					
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.						25a. DATE REC'D. BY REGISTRAR AUG 29 1979		25b. REGISTRAR'S SIGNATURE Pietro McCready			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 2 1 0 9 0

1 DECEASED NAME (TYPE OR PRINT) WALTER		FIRST --		MIDDLE --		LAST Kowalski		2a DATE OF DEATH MONTH DAY YEAR August 8, 1979		2b HOUR 44 M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 24, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Haven, Conn.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Postal Employee		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Florida		13b COUNTY Palm		13c CITY OR TOWN Lakeworth		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1122 North D Street			
14 FATHER'S NAME FIRST MIDDLE LAST Stanley Kowalski		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wanda Kowalski									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 044-12-2859		17 INFORMANT ADDRESS Mr. Robert J. Kowalski (son)							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>7-2</u> , 19 <u>79</u> , to <u>8-8</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8-8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Wilber R. Ellis, Jr.</u>		DEGREE M.D.		22c DATE SIGNED 8-8-79							
22d PHYSICIAN'S NAME (TYPE OR PRINT) Wilber R. Ellis, Jr., M.D.		22e ADDRESS Salisbury, Maryland									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/11/79		23c NAME OF CEMETERY OR CREMATORY St. Lawrence Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE West Haven, New Haven, Conn.					
24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland				25a DATE RECD. BY REGISTRAR AUG 13 1979		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>					

BP

Wisconsin

Salisbury Peninsula General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75  
(VR A 15 (4))



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		7 9 2 1 0 9 1 REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
ERNEST						Lewis		August 20 1979		9 29 AM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE IN YEARS LAST BIRTHDAY		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
MALE		WHITE		SEPT. 13, 1908		70 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				Wicomico MD.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF EMPLOYMENT OR WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital						RETIRED			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
MD.		WICOMICO		SALISBURY				201 CHESTENUT WAY			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
GEORGE LEWIS				MARY GARDNER							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS							
		NO		214-10-7012 MRS IRENE M. LEWIS				SALISBURY, MD.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes, Regret renal carcinoma, Recurrent Hematuria Cardiovascular</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (the hospital) attended the deceased from <u>8/20</u> , 19 <u>79</u> , to <u>8/20</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8/20/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Ble Agarwal</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c DATE SIGNED					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>BAL AGARWAL</u>						22e ADDRESS <u>Peninsula General Hospital.</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>B URIAL</u>		23b DATE <u>8/23/79</u>		23c NAME OF CEMETERY OR CREMATORY <u>ST. JOHN CEMETERY</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>TRUITLAND, MD.</u>					
24 FUNERAL DIRECTOR NAME <u>WILSON FUNERAL HOME</u> ADDRESS <u>SALISBURY, MD.</u>						25a DATE REC'D. BY REGISTRAR <u>AUG 27 1979</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

BP

1 2 0 1 2 8 7

Information

General Hospital

Salisbury

21-1-12

153/12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 21092 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eta Marian Long					2a. DATE OF DEATH MONTH DAY YEAR August 29 1979			2b. HOUR 11:47	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1-17-1905		6. AGE YEARS LAST BIRTHDAY 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.			
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Legal	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Wicomico Salisbury					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS N. Park Garden Apts.		
14. FATHER'S NAME FIRST MIDDLE LAST Ira Edward Gordy					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vesta Elizabeth Morris				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-14-2156		17. INFORMANT ADDRESS Salisbury Md Mr. Creston S. Long Rt. #5 Box 419					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> 3949 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Structural Valve Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>15 yr</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/17/79</u> to <u>8/29/79</u> , that (I) (we) lost saw the deceased alive on <u>8/17/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8/29-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.L. Rafferty					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-1-79		23c. NAME OF CEMETERY OR CREMATORY Wicomico Park		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.		
24. FUNERAL DIRECTOR NAME Holloway Funeral Home P.A. Salisbury, Maryland					25a. DATE RECD. BY REGISTRAR SEP 4 1979				
					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

BP

DHMH-16 20M  
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5800.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

21093

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MERRITT PAUL Marsh</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 9, 1979</b>			2b. HOUR <b>10<sup>35</sup> PM</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 12 1940</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>39</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MAINTENANCE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>POSTAL SERVICE</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>DORCHESTER</b>		13c. CITY OR TOWN <b>CAMBRIDGE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MERRITT R. MARSH</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET PAUL</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>UNK</b>		17. INFORMANT ADDRESS <b>MRS BARBARA MARSH SAME AS 13</b>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-esophageal Bleeding</b> 5715- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Partial Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cirrhosis</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Alpha one Anti-Trypsin Deficiency</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/31</b> , 19 <b>79</b> , to <b>8/9</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>8/9</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J.O. meadows</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/9/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.O. meadows M.D.</b>		22e. ADDRESS <b>Suite 31 Wesley Drive Salisbury Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>8-10-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DEL MARVA CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LEWES SUSSEX DELAWARE</b>	
24. FUNERAL DIRECTOR NAME <b>CURRAN FUNERAL HOME</b>		ADDRESS <b>308 HIGH ST</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

Salisbury Penitentiary General Hospital

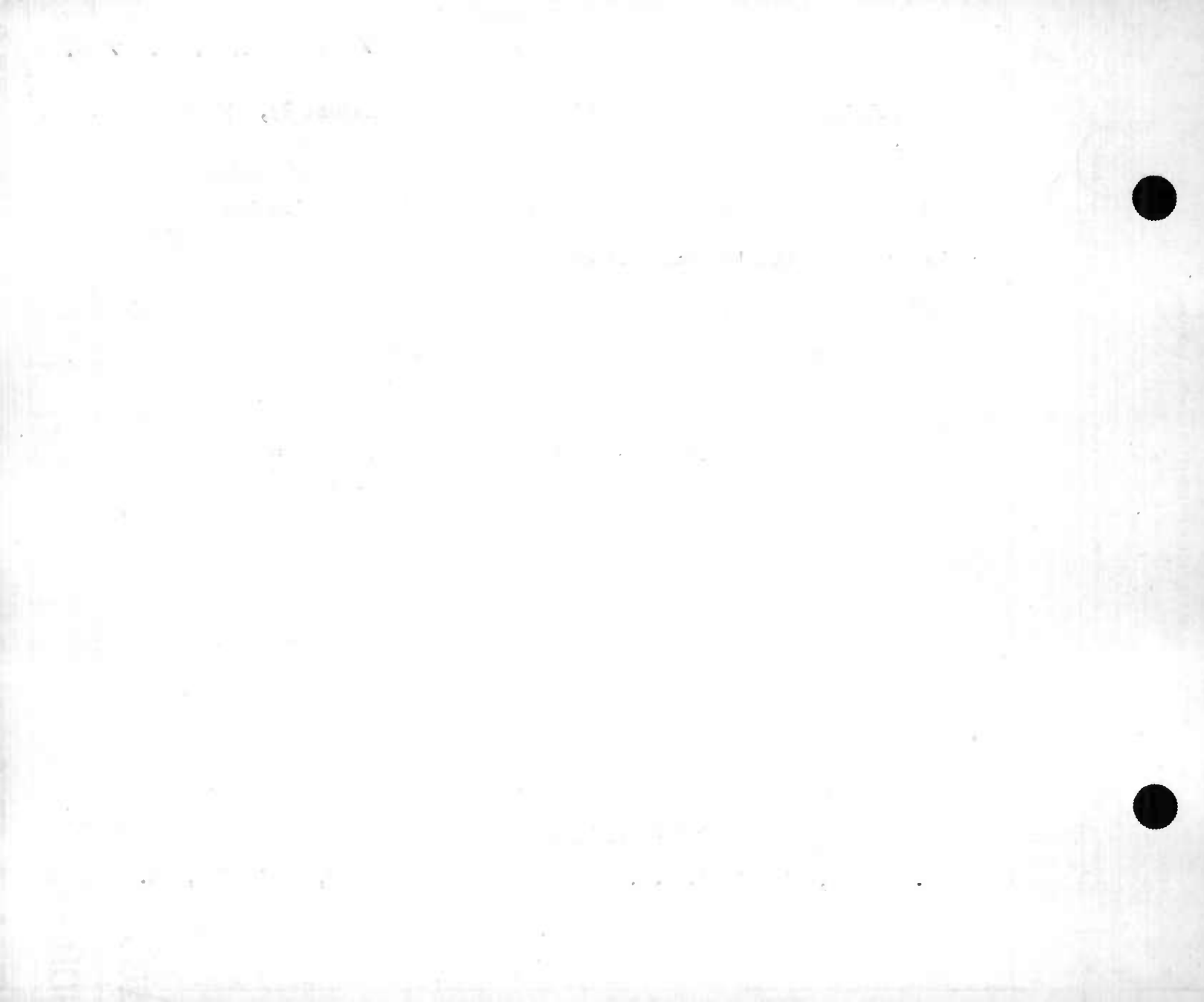


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 1 0 9 4 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
		Nellie		McAlLEN		August 23, 1979		5:15 a.m.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
F		C		APR. 23 1902		77 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NJ		USA				Wicomico MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Deer's Head Center		Domestic							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
md		Wico		Salis.						1102 West Road	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
UNK		UNK						Thelma Butler			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of breast - metastatic</u> 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
E. Peyton, Ritchings, M.D.						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		8/23/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
E. Peyton, Ritchings, M.D.						Deer's Head Center, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		8-27-79		GREEN ACRES MEM PARK		Salis Wico md					
24. FUNERAL DIRECTOR NAME						24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wrest-Fooks F/H						Salisbury md.		SEP 7 1979		L. H. B. B. B.	



BP

DHMH-16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 21095

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>James Millard McCann</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 15, 1979</b>		2b. HOUR <b>M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 3, 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b> MD	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>River Walk Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN <b>Fruitland</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James McCann</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Polly (unknown)</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-16-1655</b>		17. INFORMANT (daughter) ADDRESS <b>Mrs. Bonnie Hammond, Rt. 7, Salisbury, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4340</b> IMMEDIATE CAUSE (a) <b>cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>previous cerebrovascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>4 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION <b>6-11</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-11</b> 19 <b>76</b> , to <b>Aug 15</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Aug 14</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John T. Bulkeley</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>8-15-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John T. Bulkeley, M.D.</b>		22e. ADDRESS <b>Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/17/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury, Wicomico, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Holloway Funeral Home, Salisbury, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Holloway</b>	

100-100-100-100

100-100-100-100



100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO.		9. 21096					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
Joshua		McPHEE		August 5, 1979		8:30 A			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
Male		Blk.		April 15 1903		76 Yrs.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Miami, Florida		U.S.A.				Wilcomico		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Deer's Head Center		raised poultry					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS			
Md. Somerset		Marion		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt. 1 Box Marion, Md.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Unknown		Unknown		No.		215-32-0174		J.B. Green Marion, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adeno carcinoma of lung									
1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
L. V. Maldve, M.D.						8/5/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS					
		Deer's Head Center, Salisbury, Md. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Aug 8, 1979		Liberia		Marion Sta, Somerset		Md.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Norman J. Hard		Marion Sta, Md.		AUG 6 1979		H. J. McCready			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										9	2	1	0	9	7		
1. FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM JAMES MILES										2a. DATE OF DEATH MONTH DAY YEAR AUGUST 11 1979				2b. HOUR 1:50 PM			
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR July 25, 1919			6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.								
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) electrician			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland										13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Walnut Street	
14. FATHER'S NAME FIRST MIDDLE LAST Mark P. Miles					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Justice												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Box 8, Route #1 Russell Carter Pocomoke City, Md.										
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic malnutrition</u> 5777 DUE TO, OR AS A CONSEQUENCE OF (b) <u>multiple Abscesses</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Pancreatitis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <u>July</u> , 19 <u>79</u> , to <u>Present</u> , 19 <u>  </u> , that (1) (we) lost saw the deceased alive on <u>8/11</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>J.D. Meadows M.D.</u>					DEGREE M.D.					22c. DATE SIGNED 8/11/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.D. Meadows M.D.					22e. ADDRESS 2313 Wesley Drive Salisbury MD 21801												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 8/15/79			23c. NAME OF CEMETERY OR CREMATORY St. Mary's Epis. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md.						
24. FUNERAL DIRECTOR NAME Scott S. Milson					ADDRESS Pocomoke City, Md.			25a. DATE REC'D. BY REGISTRAR AUG 15 1979			25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>						

511

0000000000

8252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 21098	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE DUFFY MILLER						2a. DATE OF DEATH MONTH DAY YEAR AUGUST 19 1979			2b. HOUR 2:45 PM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC 31, 1920		6. AGE (IN YEARS (LAST BIRTHDAY)) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUSINESS OFFICE REP.		12b. KIND OF BUSINESS OR INDUSTRY C & P			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY PRINCE GEO 13c. CITY OR TOWN W. HYATTSVILLE						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6306 23rd AVENUE			
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK DUFFY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY A. DeSANTIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-07-1913		17. INFORMANT ADDRESS ROBERT L. B. MILLER SAME AS 13 HUSBAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Hepatic Failure DUE TO, OR AS A CONSEQUENCE OF (b) Colon Carcinoma - liver metastasis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/15, 1979, to 8/19, 1979, that (I) (we) last saw the deceased alive on 8/18, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Joseph A. Grassano						DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grassano						22e. ADDRESS PENINSULA GENERAL HOSPITAL SALISBURY MD 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/22/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN			23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUG 28 1979 [Signature]					

BP

500 UNIT, BLDG. 4, SILVER SPRING, MD. 20901	BRANKS, J. COLLINS	6/22/79	DATE OF HEAVEN	SILVER SPRING	MD.
<p>             FREDRICK              DUFFY              MARY              A.              DEWITT           </p>					
NO	578-07-1913	ROBERT L. MILLER	SAME AS IS	WISCONSIN	
<p>             HARRY AND              PRINCE GEO. W. WATTSVILLE, KY              6508 34th AVENUE              BUSINESS OFFICE BLDG. 5 1 P           </p>					
VIRGINIA	U.S.A.	XX	WATTSVILLE	WATTSVILLE	
FEMALE	WHITE	SEC 21, 1910	58	17	
BRACE	DUFFY	17	17	17	

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 21099

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BESSIE P. MITCHELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 8 1979</b>		2b. HOUR <b>2:30</b> M
3. SEX <b>Female</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 31, 1895</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>WORCESTER</b>	13c. CITY OR TOWN <b>WHALEYVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JACOB W. POWELL</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE COLLINS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>213-74-4919</b>	17. INFORMANT ADDRESS <b>POWELL MITCHELL WHALEYVILLE MD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac stroke heart disease</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>cardiac</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>7-31</b> , 19 <b>79</b> , to <b>8-8</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>8-8</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Willie R. Ellis</b>			22c. DATE SIGNED <b>8-8-79</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wilber R. Ellis</b>			22e. ADDRESS <b>Kay Drive Salisbury Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>8-11-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DALE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WHALEYVILLE WORCESTER, MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Peter Whaley SELBYVILLE, DEL.</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Hirshy McBrady</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

652515

WHITE

DEC 21 1945

83

Nicomino

USA

MARYLAND

Salisbury

Fennell General Hospital

Wife Own Home

NORTH AND WORCESTER HOSPITALS

X

MD

Corrins

WHITE

POWER

WACOB

2134-1011 POWER NICHOLS WINTERBURN RD

3-11-45 DATE

WINTERBURN NICHOLS

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

99

21100

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>ELSIE</b>		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR <b>August 12 1979</b>		2b. HOUR <b>4:18</b> M.	
3 SEX <b>Female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8/16/1928</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Peninsula General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Poultry</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b COUNTY <b>Somerset</b>		13c CITY OR TOWN <b>Princess Anne</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Walter Kohlheim</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Layton</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO.	
17 INFORMANT ADDRESS <b>Box 33</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>Pneumonia</b>		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
19c IMMEDIATE CAUSE (a) <b>1749</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>1749</b>		DUE TO, OR AS A CONSEQUENCE OF (c) <b>1749</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8/13 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>8/13</b> 19 <b>79</b> to <b>8/12</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>8/11</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <b>Joseph A. Grasso</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8-12-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph A. Grasso</b>		22e. ADDRESS <b>PGHMC SALISBURY MD 21801</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/13/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>All Saints Monue</b>		23d. LOCATION CITY <b>Princess Anne</b> COUNTY <b>Somerset</b> STATE <b>MD</b>	
24 FUNERAL DIRECTOR NAME <b>James L. Newman</b>		ADDRESS <b>Princess Anne</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>L. J. McCreedy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be submitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

001100

UNITED STATES DEPARTMENT OF THE ARMY  
HEADQUARTERS, ARMY  
WASHINGTON, D. C.

FILE

011100

10000000

Peninsula General Hospital

Col. H. B. ...

... ..

... ..

... ..

... ..

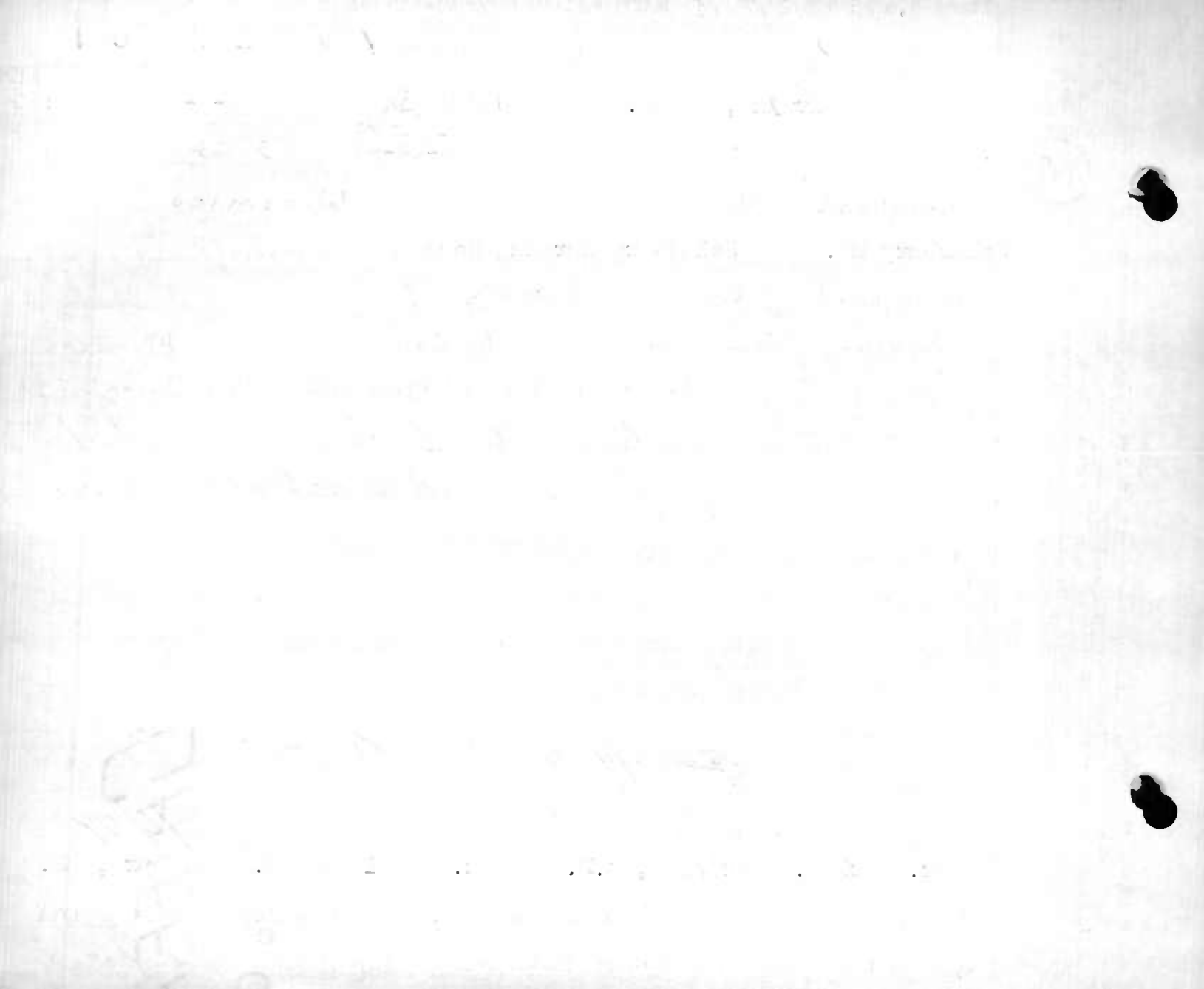
... ..  
AUG 10 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VRA 15 (4)  
25m-1/70

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>Irving, S. MUMFORD, Jr.</b>						2a. DATE OF DEATH Month Day Year <b>8-4-79</b>			2b. HOUR <b>7:40 PM</b>		
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>4-18-1894</b> <b>6-18-94</b>		6. AGE (In years (last birthday)) <b>85</b> <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.					
10. CITY OR TOWN OF DEATH <b>Salisbury Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Salisbury Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MERCHANT MARINES</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WORCESTER</b>		13c. CITY OR TOWN <b>OCEAN CITY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last <b>IRVING STURGIS MUMFORD</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>LOUISA MUMFORD</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-14-6848</b>		17. INFORMANT Address <b>IRVING S. Mumford III RT 1 Ocean City, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>yes.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>4/3</b> , 19 <b>78</b> , to <b>5/4</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>5/4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Dr. Earl M. Beardsley, M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/6/79</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>8/7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>BERLIN WOR. Md.</b>					
24. FUNERAL DIRECTOR <b>Jeann B. Priddyman</b>				ADDRESS <b>108 Wm. St. Berlin, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>			





FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 1 1 0 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) John Edward MUMFORD			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 5 1979			2b. HOUR 9:40 A.M.					
3 SEX male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1921		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD					
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) net. construction worker		12b. KIND OF BUSINESS OR INDUSTRY			
13a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Wor.		13c CITY OR TOWN Bishopville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS R.D. 1 Box 142		
14 FATHER'S NAME FIRST MIDDLE LAST Henry Mumford			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hallie Walters								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-16-4579		17 INFORMANT ADDRESS Margaret A. Mumford, Bishopville, Md.						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsisemia 5198 DUE TO, OR AS A CONSEQUENCE OF (b) Probable respiratory infection Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hematoma recently removed from R. knee									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/10/79 to 8/5/79, that (I) (we) lost saw the deceased alive on 8/5/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) move the body after death.											
22b. SIGNATURE [Signature] DEGREE						22c. DATE SIGNED			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSWALD J. BURTON						22e. ADDRESS KAY AVE SALISBURY MD. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/9/79		23c. NAME OF CEMETERY OR CREMATORY Curtis Mem. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Bishopville, Wor. C., Md.			
24 FUNERAL DIRECTOR NAME Richard T. Watson						ADDRESS Sallyville, Del.		25a. DATE REC'D. BY REGISTRAR AUG 8 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

310

• 523 •

6

[illegible]

DS.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit; then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		7 9 2 1 1 0 3		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
LOUISE E. MUMFORD				AUGUST 03, 1979								7:35 a M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
female		Black		Oct. 14, 1918		60 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				WICOMICO, MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
SALISBURY				DEER'S HEAD CENTER				housewife					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Delaware				Sussex		Selbyville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. 2 Box 87-6			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Charles H. Jones				Anna Mae Jarman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
no				222-09-2208		Alex Mumford - Selbyville, Delaware							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 1809 Adeno-epidermoid Ca of cervix DUE TO, OR AS A CONSEQUENCE OF (b). Glen. infections DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Y													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from Jun 27, 1979, to Aug. 03, 1979, that (we) lost saw the deceased alive on Aug. 03, 1979, and that in (26y) (our) opinion death occurred on the date and hour and from the causes stated above. (I did not view the body after death.)													
22b. SIGNATURE L. V. Maldve, M.D.								DEGREE M.D.		22c. DATE SIGNED 08/03/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
L. V. Maldve, M.D.				Deer's Head Center, Salisbury, Md. 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				8/7/79		Curtis Memorial Cem.		Bishopville, Wor. C., Md.					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Richard T. Watson				Millsboro, Del.				AUG 7 1979					

601 1 1 2 1 1

200 • 200

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 21104

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM STANLEY MURRAY			2a. DATE OF DEATH MONTH DAY YEAR August 13, 1979			2b. HOUR 3:40 A.M.				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 14, 1910		6 AGE IN YEARS (LAST BIRTHDAY) 68 YRS MONTHS DAYS		7 IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 200 Francis Drive	
14 FATHER'S NAME FIRST MIDDLE LAST John Samuel Murray			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Belle Taylor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 214-10-9424		17 INFORMANT (daughter) ADDRESS Mrs. Sandra M. Crouch, Salisbury, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Lymphocytic Leukemia</u> 2040 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> , 19 <u>79</u> to <u>8/13</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8/1</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Joseph A. Grosso</u> 22c. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grosso						DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-13-79		
22e. ADDRESS Salisbury, Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/16/79		23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.						25a. DATE REC'D. BY REGISTRAR AUG 16 1979		25b. REGISTRAR'S SIGNATURE <u>Patrick McCready</u>		

35  
80  
35  
221  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10115 1

Guest - Mr. C. F.

Wisconsin

Salisbury Tentative General Hospital

DATE  
2013 NOV 10

10115 1

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MINNESOTA  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21105  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
LEO		SEBASTIN	MUTH		Aug 16	19	79		9 P	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR	2e. MIN.	
Male	White	Nov. 15, 1901	77 YRS.			Aug. 17	19 79	11	20 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.				Wicomico				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		503 Truitt Street				Ret. Western Electric				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
Maryland		Wicomico		Salisbury				503 Truitt St.		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Joseph Muth				Margaret Kuhl						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS				
No		215-74-4355		Rose D. Muth		503 Truitt St. Salisbury, Md. (Wife)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>4 yrs</u> <u>4 yrs</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>myocardial infarctions x 2, carotid endarterectomy</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1) OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>John T Bulkeley</u>		TITLE (SPECIFY) M.D. <u>Deputy</u>		MEDICAL EXAMINER		DATE SIGNED <u>8-17-79</u>				
EXAMINER'S NAME (TYPE OR PRINT) <u>John T Bulkeley</u>		ADDRESS <u>Salisbury, Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		8/20/1979		New Cathedral Cem.		Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Hill-Baker-Bounds, Salisbury, Md.				AUG 21 1979		<u>Henry Melby</u>				

2011

X

RECEIVED THE NATIONAL ARCHIVES  
MAY 19 1961



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

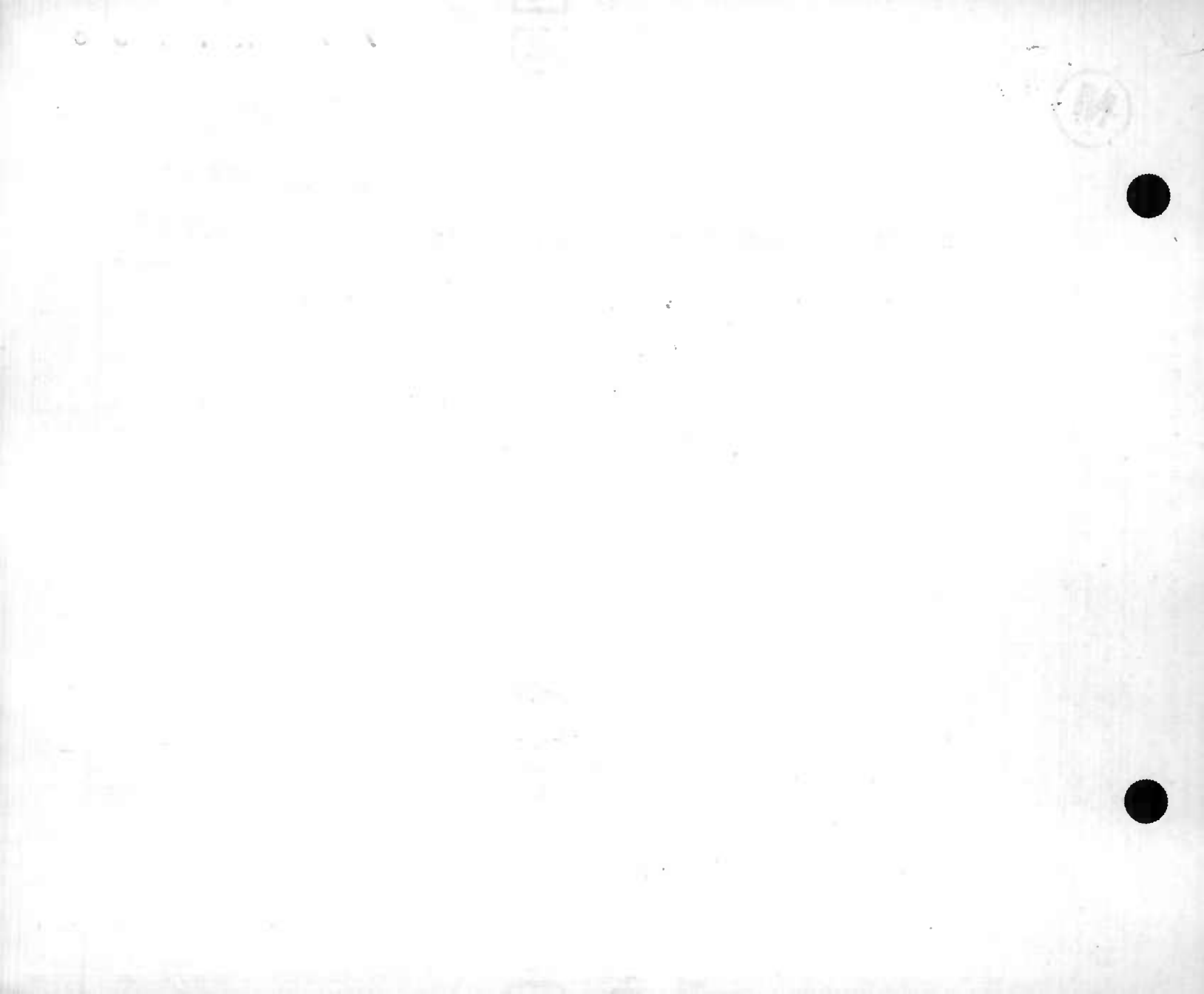


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of the certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 21106	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 30						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Olin Charles NEWELL					2a. DATE OF DEATH MONTH DAY YEAR AUGUST 30 1979				2b. HOUR 30		
3 SEX M		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 12-4-1922		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.					
10 CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PENINSULA GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Mfr. Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Wicomico 13c. CITY OR TOWN Salisbury					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 117 Johnson Dr.				
14 FATHER'S NAME FIRST MIDDLE LAST James Arthur Newell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Mary Renfrew						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 10-1945 to 042-16-5494		17 INFORMANT Mrs. Dorcas L. Newell		ADDRESS Salisbury, Maryland 117 Johnson Dr.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colon Cancer - Epidermoid Ca</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/15 19 79, to 8/30 19 79, that (I) (we) last saw the deceased alive on 8/29 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Joseph A. Grasso</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-2-79		23c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery		23d. LOCATION CITY OR TOWN Mardela Wic. COUNTY STATE Md.					
24 FUNERAL DIRECTOR NAME Holloway Funeral Home P.A. Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR SEP 4 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC. NO. 21107	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ETHEL LEVINIA OLIPHANT</b>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH DAY YEAR <b>8-10-79</b>		2b. HOUR <b>1 A</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 23 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YR. MONTHS DAYS <b>19</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8-10-79</b> 19 <b>9:20A</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mt. Vernon, Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>712 Hammond St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>712 Hammond St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adolphus White</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Levinia Muir</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>same as 13</b> <b>Mr. William D. Oliphant (husband)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4029</b> IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>8-10-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>				ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8/13/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury, Wicomico, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>HOLLOWAY &amp; CO., SALISBURY, MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1979</b>		25b. REGISTRAR'S SIGNATURE <i>History McCreedy</i>			

10-10-70

10-11-70

10-12-70

10-13-70

10-14-70

10-15-70

10-16-70

10-17-70

10-18-70

10-19-70

10-20-70

10-21-70

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 21108

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Julia A. Parsons			2a. DATE OF DEATH MONTH DAY YEAR August 7 1979		2b. HOUR 7:40 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1902	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS 6 2	IF UNDER 24 HRS. HOURS MIN ---
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD		
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY ----	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Delaware	13b. COUNTY Sussex	13c. CITY OR TOWN Delmar	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Route #2	
14. FATHER'S NAME FIRST MIDDLE LAST Hermus Lowe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Lowe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No	16b. SOCIAL SECURITY NO. 221-32-2065	17. INFORMANT ADDRESS Alvin D. Parsons Delmar, Del.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTEIOSCHLECTIC CARDIO -</u> DUE TO, OR AS A CONSEQUENCE OF <u>VASCULAR DISEASE</u> (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u> <u>INDEF.</u>
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NEPHRO LETHIASIS MIGHT

19a. DATE OF OPERATION <u>No</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-1</u> , 19 <u>79</u> to <u>8-7</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8-7</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>John M. BLOXOM JR</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>8-7-1979</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN M. BLOXOM JR	22e. ADDRESS MEDICAL CENTER OF SALISBURY, MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-10-79	23c. NAME OF CEMETERY OR CREMATORY St. Stephens	23d. LOCATION CITY OR TOWN COUNTY STATE Delmar, Sussex Del.
24. FUNERAL DIRECTOR NAME William M. Short Jr	ADDRESS Delmar, Del.	25a. DATE REC'D. BY REGISTRAR AUG 13 1979	25b. REGISTRAR'S SIGNATURE Barry McCreedy

46  
30  
46  
13  
3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Wisconsin

Calderon Peninsula General Hospital

Medical Department

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 21109	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) WILLIAM GREENSBERRY PASSWATERS			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 14 1979			2b. HOUR 1:28 PM		
1. SEX MALE		4. RACE CAUS.		5. DATE OF BIRTH MONTH DAY YEAR JAN 6 1914		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE - (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARM OWNER		12b. KIND OF BUSINESS OR INDUSTRY FARMING			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DELAWARE			13b. COUNTY SUSSEX		13c. CITY OR TOWN BRIDGEVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD 2 BOX 239 - REDDEN ROAD		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HENRY PASSWATERS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GOLDEN MAE WILLIMSON PASSWATERS				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -			
16b. SOCIAL SECURITY NO. 221-10-8339				17. INFORMANT ADDRESS MARIE ALLEN PASSWATERS BRIDGEVILLE, De.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sudden pulmonary arrest 20</u> 4341 DUE TO, OR AS A CONSEQUENCE OF (b) <u>massive cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>subarachnoid hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hr 18 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>subarachnoid hemorrhage</u>											
19a. DATE OF OPERATION <u>none</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>8-1</u> 19 <u>79</u> to <u>8-14</u> 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>8-14</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>James W. Spence, MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/16/79			
22d. REGISTRAR'S NAME (TYPE OR PRINT) <u>James W. Spence, MD</u>				22e. ADDRESS 3 Medical Center, Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 17, 1979		23c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SEAFORD SUSSEX DELAWARE					
24. FUNERAL DIRECTOR NAME PAYNTER M. WATSON - SEAFORD, DEL - 19973				25a. DATE REC'D. BY REGISTRAR AUG 23 1979		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>					

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

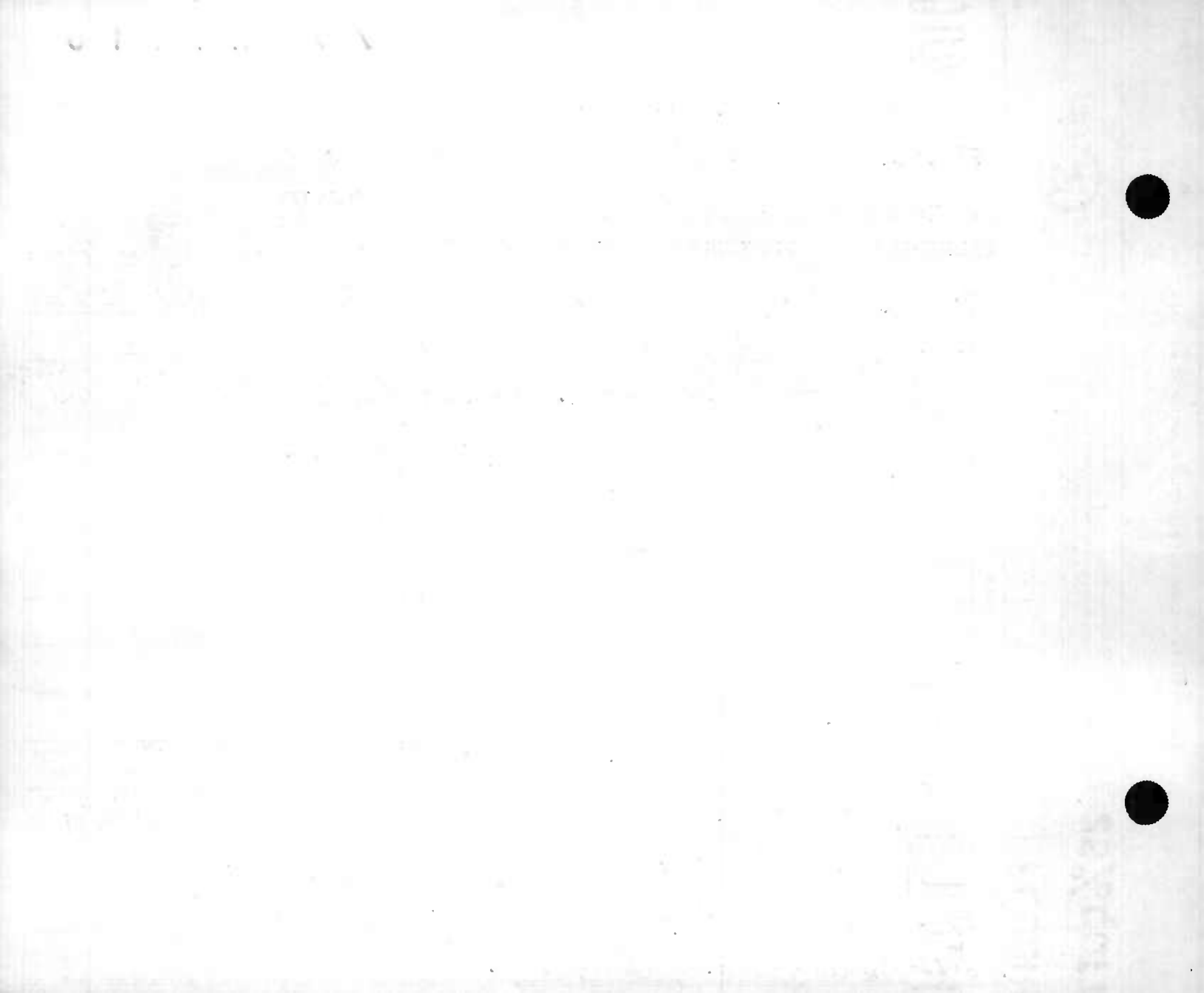
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				9 2 1 1 1 0			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MARIAN MAY Peterman</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 16 1979</b>		2b. HOUR <b>4:50</b> AM	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-12-1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b> MD.	
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PENINSULA GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>WILCO</b>		13c. CITY OR TOWN <b>HEBRON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY RUCK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Jones</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>220-26-3364</b>		17. INFORMANT ADDRESS <b>Agnes White 7205 Robin Ave Salisbury, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA with right paralysis</b> 436- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/16</b> , 19 <b>79</b> , to <b>8/16</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>8/16</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>W Ben Horner MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/16/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. Ben Horner M.D.</b>		22e. ADDRESS <b>Kay Avenue Salisbury Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8-19-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HEBRON Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Hill-Baker-Bowels</b>		ADDRESS <b>Salisbury, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Walter McCreedy</b>	

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 1 1 1 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <i>James Phoebus</i>			2a DATE OF DEATH MONTH DAY YEAR <i>August 5, 1979</i>			2b HOUR <i>9:20 P.M.</i>			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <i>JUNE 1, 1909</i>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		8b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.			
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD.</b> 13b COUNTY <b>WICOMICO</b> 13c CITY OR TOWN <b>SALISBURY</b>					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>720 EDGAR DR.</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>JAMES PHOEBUS</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAURA HEATH</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b SOCIAL SECURITY NO. <b>220-01-7219</b>		17 INFORMANT ADDRESS <b>MRS FLORENCE PHOEBUS SAME AS 13</b>				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> <b>4340</b> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Advanced cerebral atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral thrombosis &amp; diabetes mellitus</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic Heart Disease</i>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <i>7/30</i> 19 <i>79</i> to <i>8/5</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>8/5</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Joseph 2. Badros, M.D.</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>8/7/79</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph 2. Badros M.D.</i>			22e ADDRESS <i>229 Florida Avenue, Salisbury, Md.</i>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b DATE <b>8/8/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>SILOAM CEMETERY</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>SILOAM, MD.</b>		
24 FUNERAL DIRECTOR NAME ADDRESS <b>LEVIN R. WILSON SALISBURY, MD.</b>					25a DATE REC'D. BY REGISTRAR <b>AUG 13 1979</b>		25b REGISTRAR'S SIGNATURE <i>Henry M. Brady</i>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

11 11 11

Wisconsin

Peninsula General Hospital

Ballwin

11-11-11

11-11-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 9 21112		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Sedonia Carr		PLUMMER		8-21-79		130 p.m.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Black		6 15 29		50		MONTHS DAYS HOURS MIN.	
7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD.	
Maryland		U.S.A.				WICOMICO			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SALISBURY		PENINSULA GENERAL HOSPITAL		Teacher					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Somerset		Princess Anne		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		P.O. Box 3p3 Fair Haven Development	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16r. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Leon H. Carr		Theresa M. Roberts				213-22-4794		Salisbury Md. P.O. Box 1330 Dorsey Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		Cerebral Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2502								2 days	
DUE TO, OR AS A CONSEQUENCE OF		(b)		Hypertension Non-Ketotic Diabetic Coma				4 days	
DUE TO, OR AS A CONSEQUENCE OF		(c)		Diabetes Mellitus				2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET					
22a. I certify that (1) (this hospital) attended the deceased from 8-19-79 to 8-21-79, that (we) lost the deceased alive on 8-21-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (c) I did not view the body after death.)									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Roger C. Merrill		MD				8-21-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
ROGER C. MERRILL		KAY AVE. SALISBURY, MD				8/25/79		John Wesley	
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Addie James		407 Somerset Ave		AUG 27 1979		Murray McBrady			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA</b> <b>M.</b> <b>ROBINSON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>August 4, 1979</b>		2b. HOUR <b>2A</b> M
3 SEX <b>Female</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4-14-17</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN. IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.S.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10 CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OPERATOR</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>GARMENT</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>WIC</b> 13c. CITY OR TOWN <b>SHARPTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>106 CHURCH ST.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PHILLIP MYERS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA MYERS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>151-91-9034</b>	17. INFORMANT ADDRESS <b>CHARLES ROBINSON SHARPTOWN</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>lung cancer</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DO NOT WRITE IN THESE SPACES				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>7/8/79</b> , 19 <b>79</b> , to <b>8/4</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>8/4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Joseph A. Grasso</b>	22c. DATE SIGNED <b>MD</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>8-7-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FIREMEN'S CEM.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>SHARPTOWN, WIC, MD.</b>	25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1979</b>
24. FUNERAL DIRECTOR NAME <b>VLRICH FUNERAL HOME</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara M. [Signature]</b>		

19 2113

Winosco

Penitentiary General Hospital

Items #18a-22a Film G535 9/26/79 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR REG. NO. 21114

1. DECEASED NAME (TYPE OR PRINT) Susan Elsbeth Robinson			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8 27 19 79			2b. HOUR M		
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 9- 12 19 42	6. AGE (IN YEARS) (LAST BIRTHDAY) 36 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 8 27 19 79		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Perth Amboy, N. J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.		
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hosp. (DOA)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Employee (Sales)		12b. KIND OF BUSINESS OR INDUSTRY Central Supply	
13a. STATE Maryland				13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 117 Heartwood Dr.				14. FATHER'S NAME FIRST MIDDLE LAST Edward B Phillips				
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Hart				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 184-34-3914				17. INFORMANT ADDRESS Salisbury, Md. Mr. Fulton Jeffers E. Main St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7999 IMMEDIATE CAUSE (a) <u>Undetermined</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Virginia L. Dolan			TITLE (SPECIFY) Assistant			DATE SIGNED 8-28-79		
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-31-1979		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lansdale Pa.	
24. FUNERAL DIRECTOR NAME Holloway Funeral Home P.A. Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR AUG 29 1979		25b. REGISTRAR'S SIGNATURE Patricia McCreedy			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 6 AND 7 TO THE FUNERAL DIRECTOR. GIVE PAGES 8 AND 9 TO THE FUNERAL HOME. GIVE PAGES 10 AND 11 TO THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



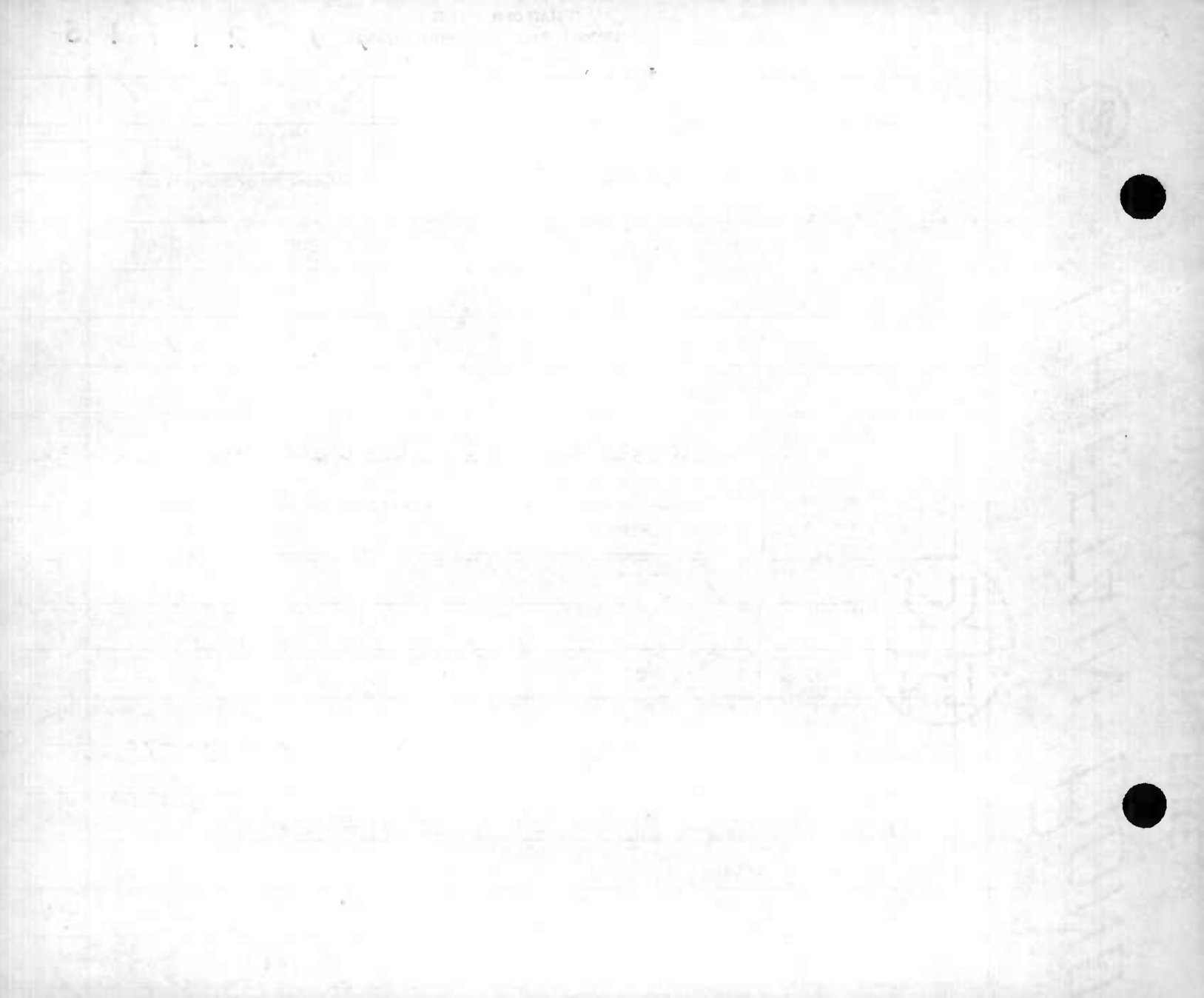


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be deposited for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES PARKER ROUNDS					2a DATE OF DEATH MONTH DAY YEAR August 8, 1979				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7b HOUR M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Snow Hill, Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.			
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 201 Priscilla Street				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b KIND OF BUSINESS OR INDUSTRY Public Service	
13a STATE Maryland		13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 201 Priscilla Street	
14 FATHER'S NAME FIRST MIDDLE LAST Harry Rounds					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie R. Sharpley				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214-10-7994		17 INFORMANT ADDRESS Mrs. Marie C. Rounds (wife) same as 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic C-V disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 19 <u>69</u> to <u>88</u> 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>8-8</u> 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Wilber R. Ellis</u>					DEGREE M.D.			22c DATE SIGNED 8/10/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Wilber R. Ellis, M.D.					22e ADDRESS Salisbury, Maryland				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/11/79		23c NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Md.			
24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland					25a DATE REC'D. BY REGISTRAR AUG 13 1979		25b REGISTRAR'S SIGNATURE <u>Henry McCreary</u>		



BP             
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						21116 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)		FIRST Maurice		MIDDLE ---		LAST Ruark		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 17 1979			2b. HOUR M A			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 12, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 17 1979			2d. HOUR M A 9:14 p.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Floor Finisher			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Cherry Way						
14. FATHER'S NAME FIRST MIDDLE LAST Walter Berry Ruark				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia Tarr										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT (brother) ADDRESS Mr. Grover H. Ruark, Salisbury, Md. 8 09 E. William S										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Multiple Injuries IMMEDIATE CAUSE (a) 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 9:00 P.M. 8/17 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by pick-up truck								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt#13/W.GordyRd, Salisbury, Wicomico Co., MD								
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE HORMEZ R. GUARD, M.D.,				TITLE (SPECIFY) Assistant				DATE SIGNED 8/20/79						
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 PENN STREET BALTIMORE, M.D 21201										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/22/79		23c. NAME OF CEMETERY OR CREMATORY Smullen Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE R.D. Worcester, Md.						
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md.						25a. DATE REC'D BY REGISTRAR AUG 23 1979		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ANTHONY</b>			2a. DATE OF DEATH MONTH <b>August</b> DAY <b>6</b> YEAR <b>1979</b>			2b. HOUR <b>8:30</b> M											
3 SEX <b>MALE</b>			4 RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH <b>SEPT</b> DAY <b>2</b> YEAR <b>1896</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS			7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>			8. IF UNDER 74 HRS HOURS <b></b> MIN <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD								
10 CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Peninsula General Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRINTER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>G.P.O.</b>					
13a. STATE <b>WASHINGTON, DC</b>			13b. COUNTY <b>WASHINGTON, DC</b>			13c. CITY OR TOWN <b>WASHINGTON, DC</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>4545 CONNECTICUT AVE., N.W.</b>					
14 FATHER'S NAME FIRST <b>NICHOLAS</b> MIDDLE <b></b> LAST <b>RUSSO</b>						15 MOTHER'S MAIDEN NAME FIRST <b></b> MIDDLE <b></b> LAST <b></b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW I</b>			17 INFORMANT <b>FLORENCE W. RUSSO</b>			ADDRESS <b>SAME AS 13 WIFE</b>								
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Stenosis</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiomyopathy. 9 months</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Coronary Artery Stenosis</b>																	
19a. DATE OF OPERATION <b>8/9/79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary Artery Stenosis</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>8/6/79</b> 19 <b>79</b> to <b>8/6/79</b> 19 <b>79</b> that (I) (we) last saw the deceased alive on <b>8/6/79</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>John G. Green</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8/6/79</b>								
22d. PHYSICIAN'S NAME (UNDER PRINT)			22e. ADDRESS <b>215 Ohio Ave Salisbury Maryland</b>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>8/9/79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>								
24 FUNERAL DIRECTOR <b>FRANCIS J. COLLINS</b> NAME ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 08 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Robert H. Harty</b>								

1945 CONNECTICUT AVE., N.W.

FLORENCE W. RUSSELL WIFE AS IS WIFE

WASHINGTON, DC

RUSSELL

NICHOLAS

NO. 1

YES

029-09-0254

Peninsula General Hospital

Calgary

U.S.A.

NEW YORK

WHITE

HAIR

SEPT. 2, 1998

X

location

WHITE

G.P.O.

DATE OF BIRTH

1/1/78

BIRTH

FRANCIS J. COLLINS

2001 SILVER SPRING, MD. 20901

SILVER SPRING

MD.

029-09-0254

FRANCIS J. COLLINS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 1 1 1 8  
REG NO.

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Ruth A. Rutherford</b>			2a DATE OF DEATH MONTH DAY YEAR <b>August 2, 1979</b>		2b HOUR <b>3 52 AM</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>7-5-1907</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.		
10 CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife Own Home</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md</b> 13b COUNTY <b>Wicomico</b> 13c CITY OR TOWN <b>Bivalve</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Edward White</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>-</b>		17 INFORMANT ADDRESS <b>Joseph A. Rutherford, Bivalve, Md</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac + renal failure</b> 4414 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Status post-operative resection abd. aortic aneurysm -</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days -</b> <b>7 days -</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Obstructive pulmonary disease -</b>					
19a DATE OF OPERATION <b>7/26/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>as above</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/25</b> , 19 <b>79</b> , to <b>8/2</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>8/1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Cerecian P. Sadler M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>8/2/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William P. Sadler</b>		22e. ADDRESS <b>581156ay, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8/6/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Charles Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Farmington, NY</b>	
24 FUNERAL DIRECTOR NAME <b>Carl W. Smith</b> ADDRESS <b>Bivalve, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>AUGO 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony A. Calady</b>	

BP



00110010

Estimote Labeled Kinetics

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled within 72 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 79 21119							
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Ivatury Gowri Sankaran								August 28 1979	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE IN YEARS LAST BIRTHDAY		7b. HOUR	
Male		W		2 21 1922		57		6 <sup>02</sup> M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10. MONTHS DAYS HOURS MIN	
A.P. India		U.S.A.				Wicomico			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD.	
Salisbury		Peninsula General Hospital		Teacher		U.M.E.S. College			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Somerset		Princess Anne				Princess Anne Estate 806 S. College Place	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
Ivatury Nagabhushanarao		Ivatury Venkayamma		No		017-28-4810		Anasuya I. Sankaram	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)	
4149				1) Cardio-pulmonary Arrest		2) Dechonic Heart Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause lost.								MINS	
								YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) this hospital attended the deceased from 1977, 1977, to 7/28, 1977, that (b) (we) lost saw the deceased alive on 7/28, 1977, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.		22b. SIGNATURE Ananda M. Woon		DEGREE 10 ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/24/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Donald M. Wood		2150 Ohio Ave Salisbury Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		8-30-1979		Delmarva Crematory		Lewes Delaware			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Holloway Funeral Home P.A. Salisbury, Md				SEP 4 1979		Holloway			

BP



Wichita, Kan.

Pennsylvania General Hospital

Philadelphia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 2 1 1 2 0 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
WALLACE		MILTON		SCOTT				August 17, 1979		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		March 16, 1920		59 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Willards, Md.		USA				WICOMICO MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		116 Marvel Road				Contractor		Paving			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		116 Marvel Road			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Arthur M. Scott		Sarah B. Powell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (daughter) ADDRESS							
Yes		WW II		215-18-4711		Mrs. Susan S. Palmer, Delmar, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Lung Cancer</u>											
1629 DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>3/7</u> , 19 <u>29</u> , to <u>8/7</u> , 19 <u>79</u> , that (I) (the) last saw the deceased alive on <u>8/7</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Joseph A. Grasso</u>		MD						8/21/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Joseph A. Grasso, M.D.		Salisbury, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE			
Burial		8/20/79		Wicomico Memorial Park		Salisbury, Wic., Maryland					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HOLLOWAY FUNERAL HOME, Salisbury, Maryland						AUG 23 1979		<u>Henry McBrady</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) VINTON DOWNES Shufelt			2a. DATE OF DEATH MONTH DAY YEAR August 8, 1979		2b. HOUR 11:35 P. M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 21, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Federalburg, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b. KIND OF BUSINESS OR INDUSTRY Church	
13a. STATE Maryland			13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Friss Shufelt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lura E. McMahan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-12-4314	17. INFORMANT ADDRESS Mrs. Edith S. Shufelt same as 13 (wife)			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 5334 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Block septum vlen</u> (c) <u>Block septum vlen</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION 8/7		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Block septum vlen		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Richard E. Hughes		22c. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Hughes, M.D.				22d. ADDRESS Salisbury, Md.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/12/79	23c. NAME OF CEMETERY OR CREMATORY Unity Washington Church Cem., Hurlock		23d. LOCATION CITY OR TOWN COUNTY STATE Maryland	
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, SALISBURY		25a. DATE RECEIVED BY REGISTRAR AUG 13 1979		25b. REGISTRAR'S SIGNATURE		

Subsidiary Penitentiary General Hospital



DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21122  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST John		MIDDLE -		LAST Simone		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 19		2b. HOUR M		
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 10 10 1899		6. AGE (IN YEARS) LAST BIRTHDAY 79 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 13 1979		2d. HOUR M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.						
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker		12b. KIND OF BUSINESS OR INDUSTRY Milk Plant				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE N.Y.		13b. COUNTY Rockland Co.		13c. CITY OR TOWN West Nyack		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2 Hampshire Court				
14. FATHER'S NAME FIRST Vito		MIDDLE -		LAST Simone		15. MOTHER'S MAIDEN NAME FIRST Carmine		MIDDLE -		LAST Racanello		ADDRESS 2 Hampshire Court West Nyack, N.Y.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 090-14-5968		17. INFORMANT Mrs. Carmine Hack								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertensive cardiovascular disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. 410-										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min yrs yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE John S Bulkeley				TITLE (SPECIFY) Deputy				DATE SIGNED 8-14-79				
EXAMINER'S NAME (TYPE OR PRINT) John T Bulkeley				ADDRESS Salisbury, Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/16/79		23c. NAME OF CEMETERY OR CREMATORY St. Anthony's Cem.		23d. LOCATION CITY OR TOWN Nanuet		COUNTY Rockland		STATE N.Y.		
24. FUNERAL DIRECTOR NAME Anna A. Bulkeley				ADDRESS 108 Williams St. Berlin, Md.		25a. DATE REC'D. BY REGISTRAR AUG 17 1979		25b. REGISTRAR'S SIGNATURE [Signature]				

2 2 1 2 2

THE UNIVERSITY OF CHICAGO



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

21123

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Eleanor Leona Skiles</i>			2a DATE OF DEATH MONTH DAY YEAR <i>August 31 1979</i>			2b HOUR <i>549 PM</i>			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Nov. 6, 1922</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>56</i>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <i>YRS</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD.			
10 CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
13a STATE <i>Virginia</i>		13b COUNTY <i>Accomack</i>		13c CITY OR TOWN <i>Wallops Island</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <i>18 Wallops Road</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>George Szabarianski</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emily Milosh</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>158-14-9042</i>			17 INFORMANT ADDRESS <i>James Skiles, Wallops Island, Virginia</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Lung Cancer</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>8/23</i> , 19 <i>79</i> , to <i>8/31</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>8/31</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Joseph A. Grasso</i>					DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph A. Grasso, M.D.</i>					22e ADDRESS <i>1300 S. Division St. Salisbury, Md.</i>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b DATE <i>9-4-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rosedale Memorial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Linden, New Jersey</i>		
24 FUNERAL DIRECTOR NAME ADDRESS <i>Salvy Funeral Home, Chincoteague, Virginia</i>					25a. DATE REC'D. BY REGISTRAR <i>SEP 17 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21-12-0

Historico

Perinatal General Hospital

Salisbury

SECRET NO. 110

SECRET NO. 110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75  
(VR A 15 (4))

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21124

1. DECEASED NAME (Type or Print) <b>ROSALEE L Smiley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 17 1979</b>			2b. HOUR <b>6:30 P.M.</b>			
3. BIRTH PLACE (State or Foreign Country) <b>Del.</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>9 9 34</b>			
6. CITIZENSHIP (What Country) <b>U.S.A.</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS			
9. CITY OR TOWN OF DEATH <b>Salisbury</b>			10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) <b>Peninsula General Hospital</b>			11. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.			
12. USUAL RESIDENCE (If nursing home or other institution, give residence before admission) 13a. STATE <b>MD.</b> 13b. COUNTY <b>Wi.</b> 13c. CITY OR TOWN <b>Salis</b>			14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			15. STREET ADDRESS <b>314 CATHERINE ST.</b>			
16. FATHER'S NAME FIRST <b>LEROY</b> MIDDLE <b>GAINES</b> LAST <b>PEARL</b>			17. MOTHER'S MAIDEN NAME FIRST <b>PEARL</b> MIDDLE <b>Robert's</b> LAST <b>SALES MD.</b>			18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, ENTER UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)			
19. SOCIAL SECURITY NO. <b>218-30-1724</b>			20. INFORMANT <b>JEFFREY SMILEY</b>			21. ADDRESS <b>Salis MD.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> 1550 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatic cellulosa Cirrhosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>8/13</b> , 19 <b>79</b> , to <b>8/17</b> , 19 <b>79</b> , that (1) <b>we</b> last saw the deceased alive on <b>8/17</b> , 19 <b>79</b> , and that in my <b>best</b> opinion death occurred on the date and hour and from the causes stated above. <b>I</b> <b>did not</b> view the body after death.									
22b. SIGNATURE <b>Joseph A. Gensso</b>			DEGREE <b>MD</b>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type or Print) <b>Joseph A. Gensso</b>			22e. ADDRESS			22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			
23d. LOCATION CITY OR TOWN COUNTY STATE			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE			
24. FUNERAL DIRECTOR NAME <b>West-Father Salis</b> ADDRESS <b>Salis MD.</b>			24b. DATE REC'D. BY REGISTRAR			24c. REGISTRAR'S SIGNATURE			

BP

Wichita

Penitentiary General Hospital

Salisbury

AUG 2 1978

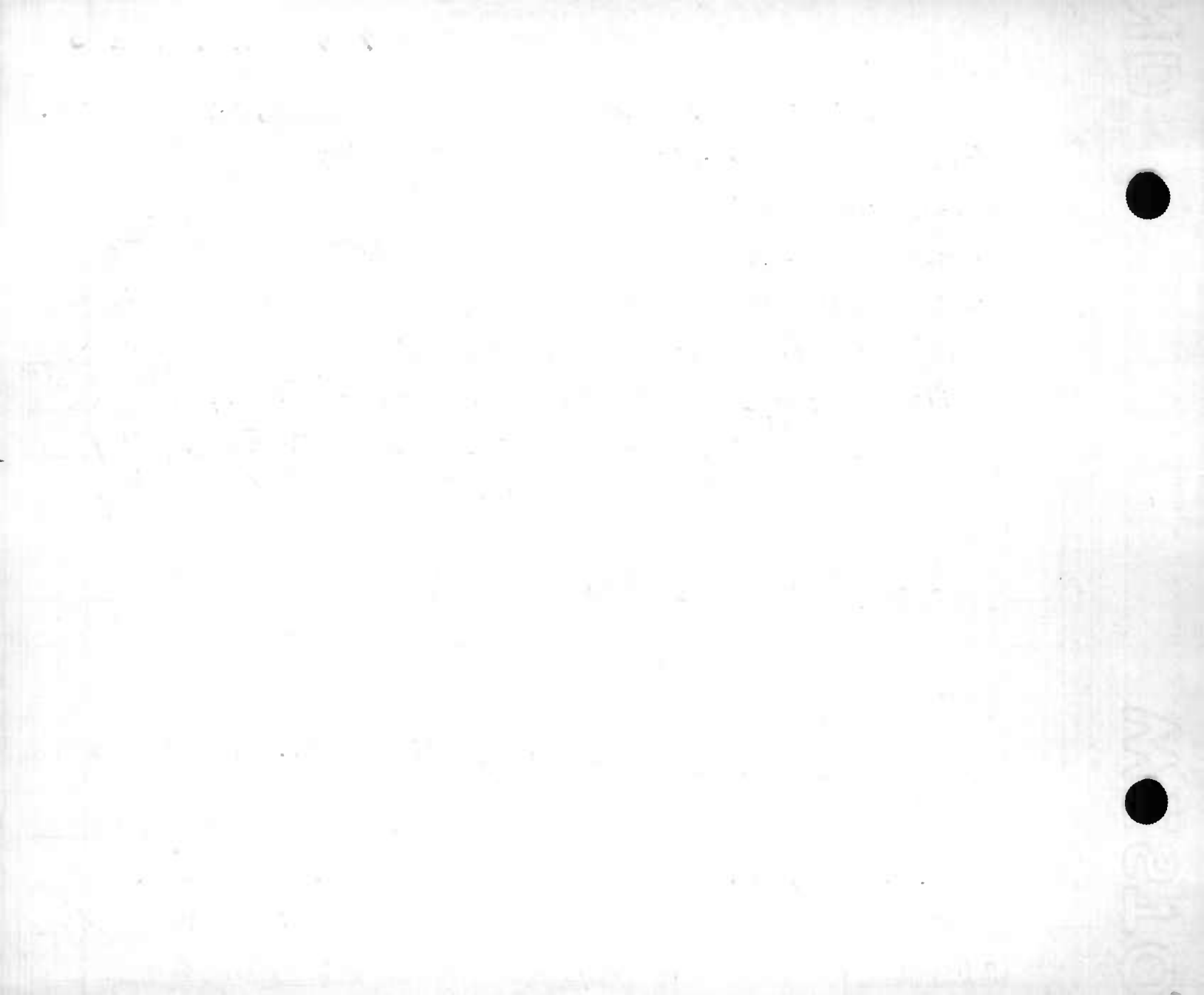
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										9 21125	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
ARIETTA HAMMOND SMITH						AUGUST 31, 1979			9:15 a.m.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		7 4 1895		84					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND			U.S.A.						WICOMICO MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Deer's Head Center			Retired School Teacher					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD		Wicomico		Salisbury				803 Camden Ave			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Thomas A. Smith				Alice Ruark							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				219-36-5818		Miss Belle J. Smith		803 Camden Ave Salisbury, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 Ca of heart & gen. arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF (b) Ca of colon & metastasis											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) I.p. EVA, & D. hemiparesis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jun 15, 1979, to Aug 31, 1979, that (we) lost the deceased alive on Aug 31, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (see) (add) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
L. V. Maldve, M.D.									08/31/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
L. V. Maldve, M.D.			Deer's Head Center, Salisbury, Md. 21801								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			9/3/1979		Parsons Cem.		Salisbury Wic. Md.				
24. FUNERAL DIRECTOR (NAME)						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hill-Baker-Bounds Salisbury, Md.						SEP 6 1979		R. J. Baker			

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
FOR 1- STATE REGISTRAR		REG. NO. 21126									
1. DECEASED NAME (TYPE OR PRINT)		FIRST DAVID		MIDDLE L.		LAST SMITH		2a. DATE KNOWN OF DEATH		2b. DATE OF ESTI- MATED	
3. SEX Male		4. RACE AA		5. DATE OF BIRTH MONTH DAY YEAR 10 30 25		6. AGE (IN YEARS) (BIRTHDAY) 53 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico		2c. DATE PRONOUNCED DEAD 8-29-79		2d. HOUR 9:58A	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Mill			
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 72			
14. FATHER'S NAME FIRST MIDDLE LAST William Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Taylor		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-20-3008		17. INFORMANT Lillie Miller		ADDRESS Rt. 1 Box 172 Pocomoke, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Earl L. Royer</u>				TITLE (SPECIFY) Deputy				DATE SIGNED 8-30-79			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION REMOVAL (SPECIFY) Burial		23b. DATE 9-1-79		23c. NAME OF CEMETERY OR CREMATORY John Neck Cem.		23d. LOCATION (CITY OR TOWN) COUNTY STATE Pocomoke Wicomico Md.					
24. FUNERAL DIRECTOR NAME Savage Funeral Home, New Church, Va.				ADDRESS		25a. DATE SEP 11 1979					



colours

MM

VERO

1911

1911

1911

1911

1911

1911

1911

1911

X X

X

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			7 9 2 1 1 2 7 REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) ROBERT REESE SMULLEN			2a DATE OF DEATH MONTH DAY YEAR AUGUST 11 1979			2b HOUR 3 30 P.M.			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1926		6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD			
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Fitter		12b KIND OF BUSINESS OR INDUSTRY Plumbing	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 110 Prince Street	
14 FATHER'S NAME FIRST MIDDLE LAST George W. Smullen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roxie B. Phippin						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-16-7369		17 INFORMANT (wife) ADDRESS Mrs. Gladys M. Smullen same as 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer 1629 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) <del>the hospital</del> attended the deceased from 8/11/79, 19 79, to 8/11/79, 19 79, that (I) <del>found</del> last saw the deceased alive on 8/11/79, 19, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I <del>over</del> did) (did not) view the body after death.									
22b SIGNATURE <i>Joseph A. Grasso</i>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c DATE SIGNED 8-12-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso		22e ADDRESS PGH/MC SALISBURY, MD 21801							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/14/79		23c NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR AUG 15 1979		25b. REGISTRAR'S SIGNATURE			

BP

121121

121121

121121

121121

121121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				9 21128			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>HAROLD L. SNEAD</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 29 1979</b>		2b. HOUR <b>6:12</b> M	
3. SEX <b>M</b>		4. RACE <b>N</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 2 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>INDIANA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b> MD.	
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PENINSULA GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF EMP</b>	
13a. STATE <b>PA</b>		13b. COUNTY <b>PHILA C</b>		13c. CITY OR TOWN <b>PHILA PA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William SNEAD</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Hattie LERMAN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>180-12-9182</b>		17. INFORMANT ADDRESS <b>AS NGS SNEAD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5789</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Circumstances of the Blotter</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>8/28/79</b> to <b>8/29/79</b> , that (I) (we) lost saw the deceased alive on <b>8/28/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (If not, state the body of death).							
22a. SIGNATURE <b>David P. Largey</b>				DEGREE <b>MD</b>		22b. DATE SIGNED <b>8/31/79</b>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David P. Largey</b>				22d. ADDRESS <b>Medical Center Salisbury Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-5-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NORTHWOOD CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PHILA PHILA PA</b>	
24. FUNERAL DIRECTOR NAME <b>Addie James</b> ADDRESS <b>James Funeral Home Princess Anne</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 4 1979</b>		25b. REGISTRAR'S SIGNATURE <b>L. J. H. H. H.</b>	



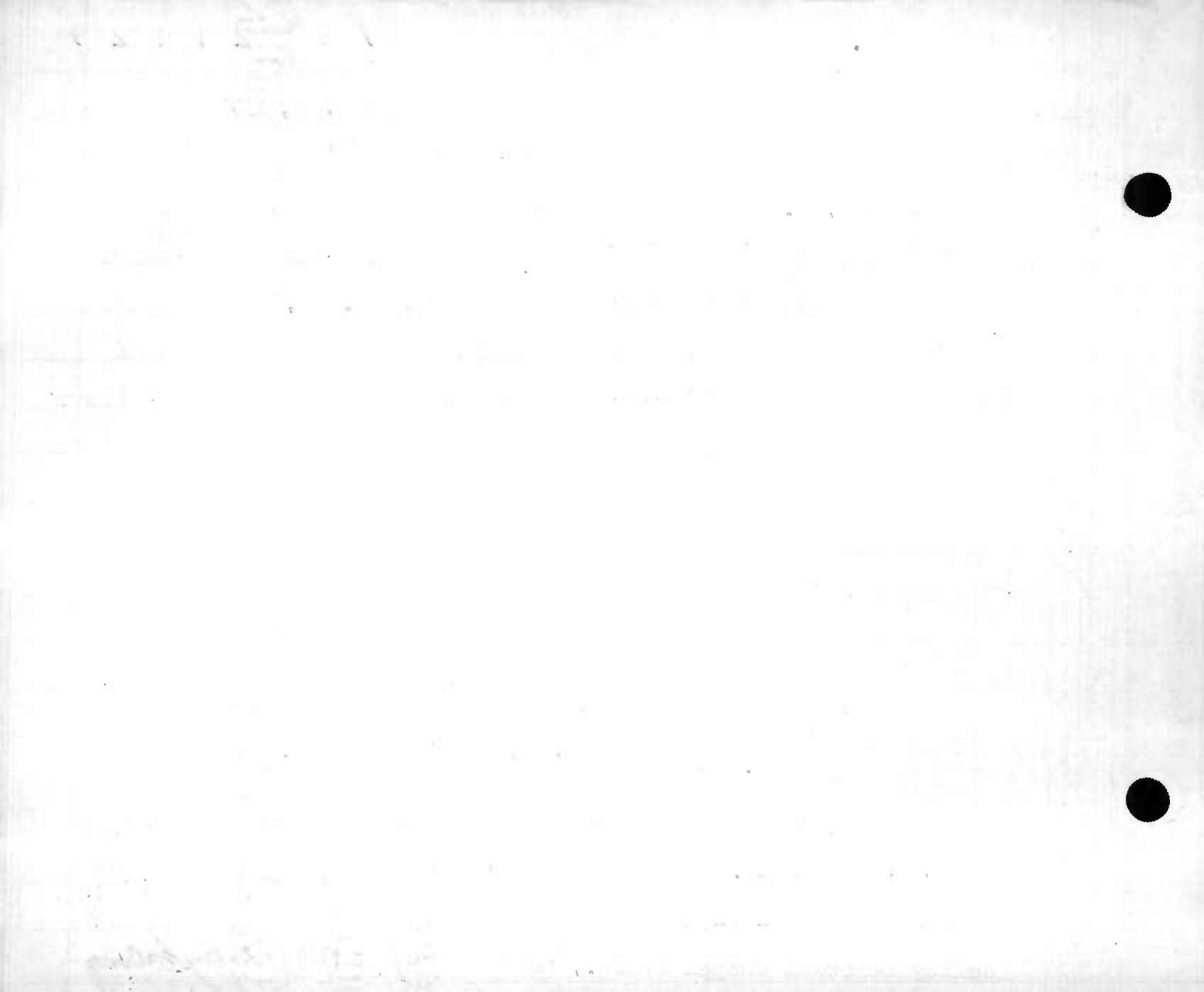
TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1. FOR STATE REGISTRAR		7 9 2 1 1 2 9				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
JAMES						SNEAD		AUG. 22, 1979		9:00am	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		Negro		8 12 95		84 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Pungoteague, Va.		USA		WICOMICO, MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SALISBURY		DEER'S HEAD CENTER				laborer		Lumber			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md		Worcester		Berlin				Rt. #2, Box 346			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
James		Snead		Alicia		Snead					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
no		222-16-5645A		Caroline Purnell same as above							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 185- Ca of prostate											
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
Fr. of 2 tumor											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22 I certify that (this hospital) attended the deceased from Feb. 22, 19 78, to Aug. 22, 19 79, that (we) lost saw the deceased alive on Aug. 22, 19 79, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.											
22a. SIGNATURE		DEGREE						22c. DATE SIGNED			
L. V. Maldve, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						08/22/79			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
L. V. Maldve, M.D.		Deer's Head Center, Salisbury, Md. 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		8-25-79		Evergreen Cemetery		Berlin Worcester Md					
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Jolley Memorial Chapel		Salis., Md		AUG 28 1979		[Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 21130							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Francis STRAN						2a DATE OF DEATH MONTH DAY YEAR August 23 1979		2b HOUR 8:05 AM	
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Jan. 4 1934		6 AGE (IN YEARS LAST BIRTHDAY) 45 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		8b CITIZEN OF WHAT COUNTRY? U.S.A.		8c MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b KIND OF BUSINESS OR INDUSTRY dry wall	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Worcester Bishopville						13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS	
14 FATHER'S NAME FIRST MIDDLE LAST Dalton Stran				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Maine Baker					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes 15-6-'58				16b SOCIAL SECURITY NO. 219-30-1017		17 INFORMANT ADDRESS Mayarie Stran Bishopville, Md			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Insufficiency 2000 DUE TO, OR AS A CONSEQUENCE OF (b) Histocytic lymphoma DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 8/20 19 79, to 8/23 19 79, that (I) (we) last saw the deceased alive on 8/22 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Joseph A. Grasso						DEGREE MD		22c DATE SIGNED P-23-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso						22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/26/79		23c NAME OF CEMETERY OR CREMATORY Odd Fellows		23d LOCATION CITY OR TOWN COUNTY STATE Bishopville Wor. Md.			
24 FUNERAL DIRECTOR NAME Richard T. Watson						25a DATE RECD. BY REGISTRAR AUG 27 1979		25b REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR			9 2 1 1 3 1 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>LESLIE B. Tarbutton</b>			2a. DATE OF DEATH <b>August 28 1979</b>			2b. HOUR <b>4:35 PM</b>			
3 SEX <b>male</b>		4 RACE <b>caucasian</b>		5. DATE OF BIRTH <b>June 30, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b>			
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PENINSULA GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>manager-bulk sales-dog food</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>dog food</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>520 J. Alabama-Oak Hill</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Raymond Tarbutton</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence O. Leonard</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. 11</b>		17. INFORMANT <b>Frances T. Tarbutton</b>		ADDRESS <b>see item 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident secondary to</b> <b>4/148</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal cardiac output syndrome &amp; chronic</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Compensated Heart failure.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>old embolic infarct with left bundle branch block.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/18</b> 19 <b>78</b> to <b>8/28</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>8/28</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Joseph Z. Badras</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>8/28/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph Z. Badras</b>				22e. ADDRESS <b>229 Florida Ave Salisbury Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-31-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton, Talbot, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>				ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 4 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert H. Badras</b>	

119

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21132

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Annie</b>		FIRST <b>DALE</b>		MIDDLE <b>Taylor</b>		LAST		20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <b>8</b> DAY <b>16</b> YEAR <b>1979</b>				26. HOUR <b>7:15 PM</b>							
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>SEPT.</b> DAY <b>7</b> YEAR <b>1906</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>72</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>		IF UNDER 24 HRS. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>		21. DATE PRONOUNCED DEAD <b>Aug. 16 1979</b>		2d. HOUR <b>7:15 PM</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b> MD.							
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE WIFE</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>							
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>WICOMICO</b>				13c. CITY OR TOWN <b>WILLARDS</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>RT 346</b>			
14. FATHER'S NAME FIRST <b>MILTON</b> MIDDLE <b>M.</b> LAST <b>DALE</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b>POWELL</b> LAST <b></b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b></b>				16b. SOCIAL SECURITY NO. <b>213-4-7313</b>				17. INFORMANT ADDRESS <b>ELIZABETH DASEY WILLARDS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrhythmia</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>arteriosclerotic heart disease</b> (c) <b></b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>min</b> <b>yrs</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>John G Bulkeley</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>8-17-79</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>John T Bulkeley</b>				ADDRESS <b>Salisbury, Md.</b>															
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>				23b. DATE <b>8-19-79</b>				23c. NAME OF CEMETERY OR CREMATORY <b>DALE</b>				23d. LOCATION CITY OR TOWN <b>WHALEYVILLE</b> COUNTY <b>WORCESTER</b> STATE <b>MD.</b>							
24. FUNERAL DIRECTOR NAME <b>Peter Whaley Sillegers</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 23 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>											

No.	Name	Address	City	State	Date
1	John A. Smith	123 Main St.	New York	NY	1910
2	James B. Jones	456 Elm St.	Chicago	IL	1911
3	William C. Brown	789 Oak St.	Philadelphia	PA	1912
4	Robert D. White	101 Pine St.	Boston	MA	1913
5	Charles E. Black	202 Cedar St.	San Francisco	CA	1914
6	Frank G. Green	303 Birch St.	Los Angeles	CA	1915
7	George H. Hall	404 Spruce St.	Portland	ME	1916
8	Harold I. King	505 Ash St.	Seattle	WA	1917
9	Arthur J. Lee	606 Willow St.	Denver	CO	1918
10	Edward K. Miller	707 Poplar St.	St. Louis	MO	1919
11	Frederick L. Moore	808 Hickory St.	Indianapolis	IN	1920
12	William M. Taylor	909 Walnut St.	Cincinnati	OH	1921
13	Charles N. Evans	1010 Chestnut St.	Pittsburgh	PA	1922
14	Robert O. Hill	1111 Locust St.	St. Paul	MINN	1923
15	Frank P. Scott	1212 Madison St.	Minneapolis	MINN	1924
16	George Q. Adams	1313 Monroe St.	Des Moines	IA	1925
17	Harold R. Baker	1414 Jefferson St.	Omaha	NE	1926
18	Arthur S. Clark	1515 Adams St.	Lincoln	NE	1927
19	Edward T. Lewis	1616 Franklin St.	Sioux Falls	SD	1928
20	Frederick U. Walker	1717 Washington St.	Rapid City	SD	1929
21	William V. Young	1818 Lincoln St.	Yankton	SD	1930
22	Charles W. Allen	1919 Jackson St.	Brookings	SD	1931
23	Robert X. Wright	2020 Grant St.	Wichita	KS	1932
24	Frank Y. Green	2121 Taylor St.	Topeka	KS	1933
25	George Z. Hall	2222 Sherman St.	Lawrence	KS	1934
26	Harold A. King	2323 Webster St.	Overland Park	KS	1935
27	Arthur B. Lee	2424 Durant St.	Wichita	KS	1936
28	Edward C. Miller	2525 Lincoln St.	Wichita	KS	1937
29	Frederick D. Moore	2626 Jackson St.	Wichita	KS	1938
30	William E. Taylor	2727 Franklin St.	Wichita	KS	1939
31	Charles F. Evans	2828 Madison St.	Wichita	KS	1940
32	Robert G. Hill	2929 Monroe St.	Wichita	KS	1941
33	Frank H. Scott	3030 Jefferson St.	Wichita	KS	1942
34	George I. Adams	3131 Adams St.	Wichita	KS	1943
35	Harold J. Baker	3232 Franklin St.	Wichita	KS	1944
36	Arthur K. Clark	3333 Lincoln St.	Wichita	KS	1945
37	Edward L. Lewis	3434 Jackson St.	Wichita	KS	1946
38	Frederick M. Walker	3535 Grant St.	Wichita	KS	1947
39	William N. Young	3636 Taylor St.	Wichita	KS	1948
40	Charles O. Allen	3737 Sherman St.	Wichita	KS	1949
41	Robert P. Wright	3838 Webster St.	Wichita	KS	1950
42	Frank Q. Green	3939 Durant St.	Wichita	KS	1951
43	George R. Hall	4040 Lincoln St.	Wichita	KS	1952
44	Harold S. King	4141 Jackson St.	Wichita	KS	1953
45	Arthur T. Lee	4242 Franklin St.	Wichita	KS	1954
46	Edward U. Miller	4343 Madison St.	Wichita	KS	1955
47	Frederick V. Moore	4444 Monroe St.	Wichita	KS	1956
48	William W. Taylor	4545 Jefferson St.	Wichita	KS	1957
49	Charles X. Evans	4646 Adams St.	Wichita	KS	1958
50	Robert Y. Hill	4747 Franklin St.	Wichita	KS	1959
51	Frank Z. Green	4848 Lincoln St.	Wichita	KS	1960
52	George A. Hall	4949 Jackson St.	Wichita	KS	1961
53	Harold B. King	5050 Grant St.	Wichita	KS	1962
54	Arthur C. Lee	5151 Taylor St.	Wichita	KS	1963
55	Edward D. Miller	5252 Sherman St.	Wichita	KS	1964
56	Frederick E. Moore	5353 Webster St.	Wichita	KS	1965
57	William F. Taylor	5454 Durant St.	Wichita	KS	1966
58	Charles G. Allen	5555 Lincoln St.	Wichita	KS	1967
59	Robert H. Wright	5656 Jackson St.	Wichita	KS	1968
60	Frank I. Green	5757 Franklin St.	Wichita	KS	1969
61	George J. Hall	5858 Madison St.	Wichita	KS	1970
62	Harold K. King	5959 Monroe St.	Wichita	KS	1971
63	Arthur L. Lee	6060 Jefferson St.	Wichita	KS	1972
64	Edward M. Miller	6161 Adams St.	Wichita	KS	1973
65	Frederick N. Moore	6262 Franklin St.	Wichita	KS	1974
66	William O. Taylor	6363 Lincoln St.	Wichita	KS	1975
67	Charles P. Evans	6464 Jackson St.	Wichita	KS	1976
68	Robert Q. Hill	6565 Grant St.	Wichita	KS	1977
69	Frank R. Green	6666 Taylor St.	Wichita	KS	1978
70	George S. Hall	6767 Sherman St.	Wichita	KS	1979
71	Harold T. King	6868 Webster St.	Wichita	KS	1980
72	Arthur U. Lee	6969 Durant St.	Wichita	KS	1981
73	Edward V. Miller	7070 Lincoln St.	Wichita	KS	1982
74	Frederick W. Moore	7171 Jackson St.	Wichita	KS	1983
75	William X. Taylor	7272 Franklin St.	Wichita	KS	1984
76	Charles Y. Allen	7373 Madison St.	Wichita	KS	1985
77	Robert Z. Wright	7474 Monroe St.	Wichita	KS	1986
78	Frank A. Green	7575 Jefferson St.	Wichita	KS	1987
79	George B. Hall	7676 Adams St.	Wichita	KS	1988
80	Harold C. King	7777 Franklin St.	Wichita	KS	1989
81	Arthur D. Lee	7878 Lincoln St.	Wichita	KS	1990
82	Edward E. Miller	7979 Jackson St.	Wichita	KS	1991
83	Frederick F. Moore	8080 Grant St.	Wichita	KS	1992
84	William G. Taylor	8181 Taylor St.	Wichita	KS	1993
85	Charles H. Allen	8282 Sherman St.	Wichita	KS	1994
86	Robert I. Wright	8383 Webster St.	Wichita	KS	1995
87	Frank J. Green	8484 Durant St.	Wichita	KS	1996
88	George K. Hall	8585 Lincoln St.	Wichita	KS	1997
89	Harold L. King	8686 Jackson St.	Wichita	KS	1998
90	Arthur M. Lee	8787 Franklin St.	Wichita	KS	1999
91	Edward N. Miller	8888 Madison St.	Wichita	KS	2000
92	Frederick O. Moore	8989 Monroe St.	Wichita	KS	2001
93	William P. Taylor	9090 Jefferson St.	Wichita	KS	2002
94	Charles Q. Allen	9191 Adams St.	Wichita	KS	2003
95	Robert R. Wright	9292 Franklin St.	Wichita	KS	2004
96	Frank S. Green	9393 Lincoln St.	Wichita	KS	2005
97	George T. Hall	9494 Jackson St.	Wichita	KS	2006
98	Harold U. King	9595 Grant St.	Wichita	KS	2007
99	Arthur V. Lee	9696 Taylor St.	Wichita	KS	2008
100	Edward W. Miller	9797 Sherman St.	Wichita	KS	2009
101	Frederick X. Moore	9898 Webster St.	Wichita	KS	2010
102	William Y. Taylor	9999 Durant St.	Wichita	KS	2011
103	Charles Z. Allen	10000 Lincoln St.	Wichita	KS	2012



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 1 1 3 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Dorothy WARD Taylor			2a. DATE OF DEATH MONTH DAY YEAR August 7 1979			2b. HOUR 9 35 AM				
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 9 13 23		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired teacher		12b. KIND OF BUSINESS OR INDUSTRY education		
13a. STATE Md			13b. COUNTY Wicomico		13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. BOX 406 West Road SALISBURY, Md	
14. FATHER'S NAME FIRST MIDDLE LAST James H. WARD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie EVANS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. —		17. INFORMANT EDWARD TAYLOR		ADDRESS Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Right Intracerebral Hemorrhage 431- DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Long Standing Hypertension - Obesity. Previous Stroke with recovery										
19a. DATE OF OPERATION 8/7/79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/1/79, 19 to 8/7/79, 19, that (I) (we) last saw the deceased alive on 8/7/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Bal Agarwal						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/7/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BAL AGARWAL						22e. ADDRESS P.G.H. Salisbury Md 21801				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-79		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gox			23d. LOCATION CITY OR TOWN COUNTY STATE SALISBURY Wicomico Md		
24. FUNERAL DIRECTOR NAME Jolley Memorial Chapel						ADDRESS Rt. #2 Jersey Rd SALIS. Md		25. DATE REC'D. BY REGISTRAR AUG 8 1979		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 in relation to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00113 11



000000

California Peninsula General Hospital

AD

000000



000

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 2 1 1 3 4

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) EVELYN FRANCES (Brown) TAYLOR				2a DATE OF DEATH MONTH DAY YEAR August 9 1979				2b HOUR 7:55 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10/8/1925		6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS		8 UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework		12b KIND OF BUSINESS OR INDUSTRY none	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 610 E. Isabella St.	
14 FATHER'S NAME FIRST MIDDLE LAST John William Brown					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Berdie Esther Phippin				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO 218-20-5582		17 INFORMANT (son) ADDRESS Mr. John Earl Rathel, Jr., 609 Baker St., Salisbury, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with generalized metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary Disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>8/7/79</u> to <u>8/10/79</u> , that (I) (we) lost saw the deceased alive on <u>8/7/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Helen M. Baldado				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 8/13/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Helen Baldado				22e ADDRESS 237 FLORIDA AVE, Salisbury, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/13/79		23c NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Md.			
24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.				25a DATE REC'D. BY REGISTRAR AUG 21 1979		25b REGISTRAR'S SIGNATURE H. McBrady			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

BP

2115 A



Wisconsin

Peninsula General Hospital

Salisbury

RECEIVED  
JUN 10 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				9 2 1 1 3 5	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
MARGARET C. THOMS				8-24-79	
3. SEX	F	4. RACE	W	5. DATE OF BIRTH MONTH DAY YEAR	12-3-98
6. AGE (IN YEARS LAST BIRTHDAY)	80	7b. CITIZEN OF WHAT COUNTRY?		U.S.A.	
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Penn.		U.S.A.		Wicomico County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Salisbury		SALISBURY NURSING HOME		HOUSEWIFE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Penn.		Allegheny		Pittsburg	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		13d. STREET ADDRESS	
Edward Klicker		Margaret Catherine Bingham		1708 RIATO ST.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		167507988		Dr. Oliver Thoms, 8 Jackson Rd, Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease					
4292					
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-24-79, to 8-24-79, that (I) (we) last saw the deceased alive on 8-24-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Wilber R. Ellis M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		8-24-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
WILBER R. ELLIS, M.D.		SALISBURY, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		8-28-1979		Mt Royal Cem	
24. FUNERAL DIRECTOR (NAME)		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Bill Baker-Bounds		Salisbury Md.		AUG 28 1979	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			
		Pinkney McBratney			

6-6-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

35 80 35 201 1

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		REG. NO. 9 21136											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Nina Louise						Tingle		August 28 1979				4:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. YEARS (LAST BIRTHDAY)		8. IF UNDER 1 YEAR		9. IF UNDER 24 HRS	
F		White		10 26 1902		76		YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Wicomico-Md.		U.S.A.				WICOMICO MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
SALISBURY		PENINSULA GENERAL HOSPITAL		Housewife		Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		104 Justice Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Theodore Parsons Nicholson										Mary Catherine Marvel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		214-10-8054		Mrs. June T. Wynn		Salisbury, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4416										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) 4416										mos.			
DUE TO, OR AS A CONSEQUENCE OF (c)										1 wic			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
8-18-79		Same		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22. I certify that (I) (this hospital) attended the deceased from 8-24 19 79, to 8-28 19 79, that (I) (we) last saw the deceased alive on 8-28 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.													
22a. SIGNATURE		DEGREE		22b. DATE SIGNED									
E. KENT CARNEY				8-29-79									
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS											
E. KENT CARNEY		233 FLORIDA AVE SALISBURY MD. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		8-31-79		St. Paul's Cemetery		Chestertown		Maryland					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Holloway Funeral Home		Salisbury Maryland		SEP 4 1979		Holloway							

BP

DHMH-16 20M  
(VRA 15, 4) 7/78



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

21137

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARTHA VIRGINIA Townsend		2a. DATE OF DEATH MONTH DAY YEAR August 9 1979		2b. HOUR 330 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 11, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress	12b. KIND OF BUSINESS OR INDUSTRY Shirt Mfg.
13a. STATE Maryland	13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 708 Riverside Drive
14. FATHER'S NAME FIRST MIDDLE LAST William H. Purcell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary (Molly) Fields		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-10-7346		17. INFORMANT (daughter) ADDRESS Mardela, Md. Mrs. Madeline M. Mitchell

18. CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> 486- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Coronary Vascular Insufficiency. Atherosclerosis</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/8/79</u> to <u>8/9/79</u> that (I) (we) last saw the deceased alive on <u>8/8/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not (and) (d) and (e) the body after death.			
22b. SIGNATURE <u>[Signature]</u>	DEGREE	22c. DATE SIGNED 8/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Oswald Burton</u>	22e. ADDRESS <u>Kay Avenue Salisbury Md</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/13/79	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Md.
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, ADDRESS Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR AUG 13 1979	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Wiscasset

Salisbury Penitentiary General Hospital

*Unknown*

*Charles W. Buffum, Agitation*

*Oct 2/01 2/01 2/01*

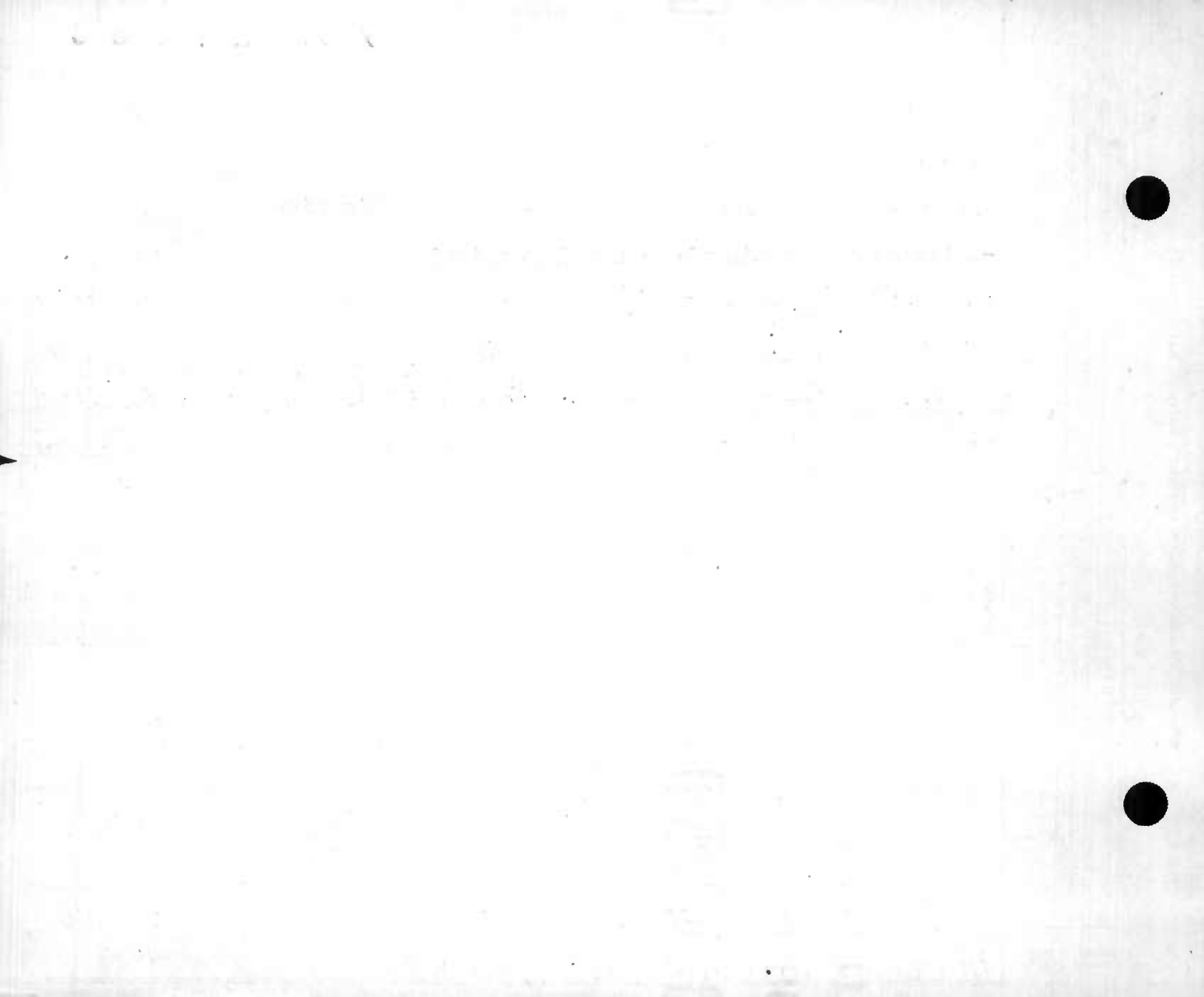
*W.H.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Charles Edward TRIBECK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 31, 1979</b>		2b. HOUR M	
3. SEX <b>MALE</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 28 1907</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>	7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CANADA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.		
10. CITY OR TOWN OF DEATH <b>-Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Self Emp.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>MARYLAND Wicomico Fruitland</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>404 S. Camden Ave</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Charles Tribeck</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>L. L. Brown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-24-2000</b>	17. INFORMANT <b>Bill Tribeck</b>		ADDRESS <b>Box 382 Salisbury, MD 21801</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carapenic Shock</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CAD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>103 r</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>7/1</b> , 19 <b>78</b> , to <b>8/31</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>8/31</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>J. L. R. Tribeck</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>8-31-79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. L. R. Tribeck</b>				22e. ADDRESS <b>PG</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/2/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Mem. Hs.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hebron Wic Md</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hill-Baker-Bounds, Salisbury, Md</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 6 1979</b>		
25b. REGISTRAR'S SIGNATURE <b>Patrick McCreedy</b>						



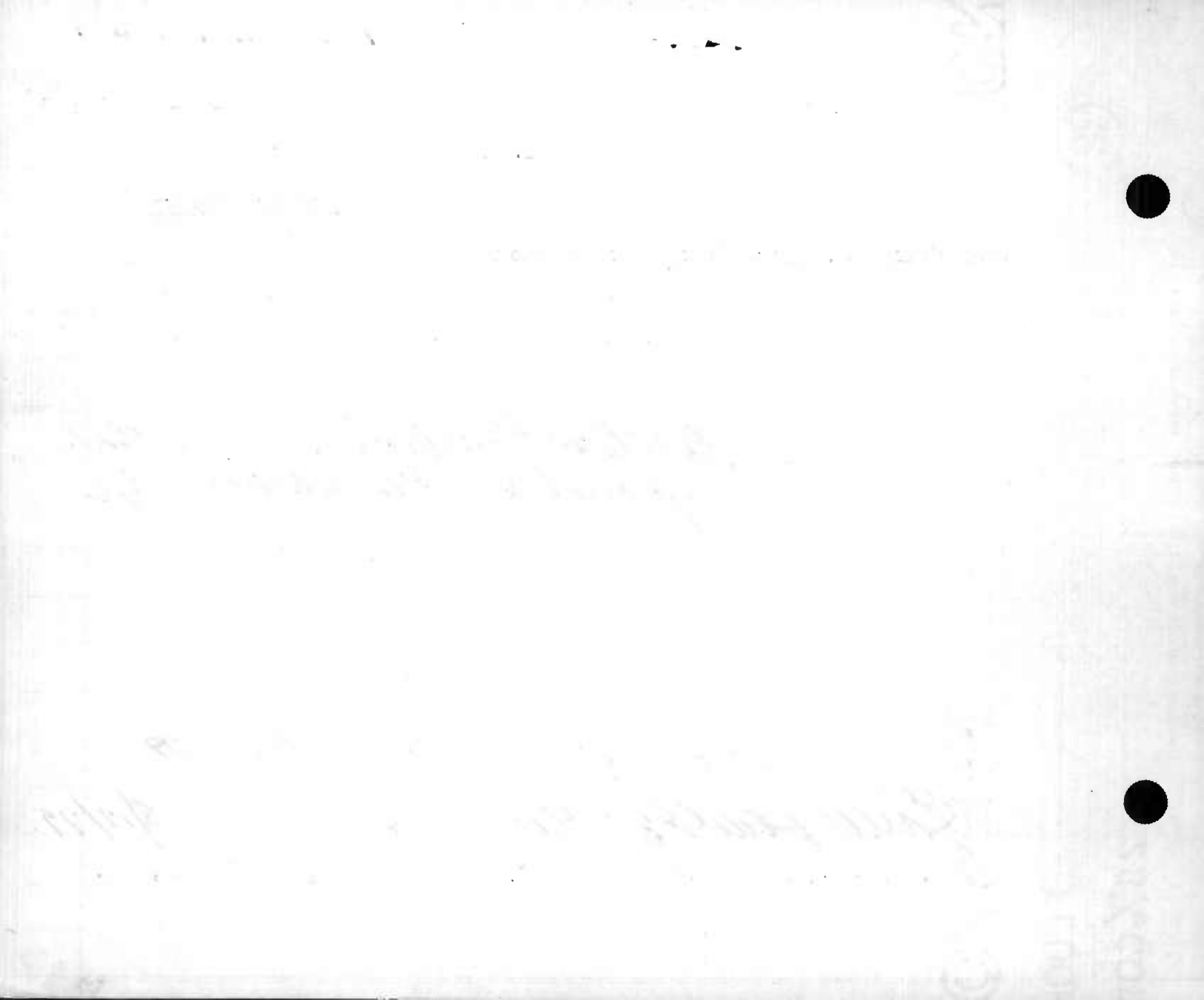
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.				9 21139					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR AM	
CATHERINE Margaret TURNER								8-16-79		11:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
F		W		8-17-00		78 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				WICOMICO COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury Md.		Salisbury Nursing Home						Housewife		none	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Wicomico		Salisbury				Ocean City Road			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
George Hudson				Mary Beauchamp							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		213-74-3221		Mr. Henry S. Niblett,		144 Pine Tree Ave. Ocean City, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>										<i>3 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized atherosclerosis</i>										<i>Yrs.</i>	
(c) <i>Due to, or as a consequence of</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>8/15/79</i> to <i>8/16/79</i> , that (I) (we) last saw the deceased alive on <i>8/15/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
<i>Earl M. Beardsley</i>		MD				<i>8/19/79</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
DR. EARL M. BEARDSLEY				RT. 50 & CIVIC AVE, SALISBURY, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		8/19/79		Wicomico Mem. Park		Salisbury, Wic., Maryland					
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE RECORDED		25b. REGISTRAR'S SIGNATURE			
Hoffway Funeral Home,				Salisbury, Md.		AUG 21 1979		<i>Earl M. Beardsley</i>			

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 21140

REG NO

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ralph James Webster			2a. DATE OF DEATH MONTH DAY YEAR August 28, 1979			2b. HOUR 12 <sup>20</sup> / <sub>4</sub> M		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 6 9 1916		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.		
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Power Operator DuPont		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Luther J. Webster			15 MOTHER'S MAIDEN NAME FIRST MIDDLE Essie Emily Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 221-10-1575		17 INFORMANT ADDRESS Mrs. Stella A. Webster, Salisbury, Maryland Et. 7 Calvin			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC LUNG CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 MONTHS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 25, 1979</u> to <u>AUGUST 28, 1979</u> , that (we) last saw the deceased alive on <u>AUGUST 27, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>E. N. Kopp MD.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD H. KLOPP					22e. ADDRESS PENINSULA GEN. HOSP.,			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-31-79		23c. NAME OF CEMETERY OR CREMATORY Springhill Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.		
24 FUNERAL DIRECTOR NAME Holloway Funeral Home P.D.A. Salisbury, Md.					25a. DATE REC'D. BY REGISTRAR AUG 29 1979		25b. REGISTRAR'S SIGNATURE <u>Richard K. Bandy</u>	

MEDICAL CERTIFICATION

9  
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

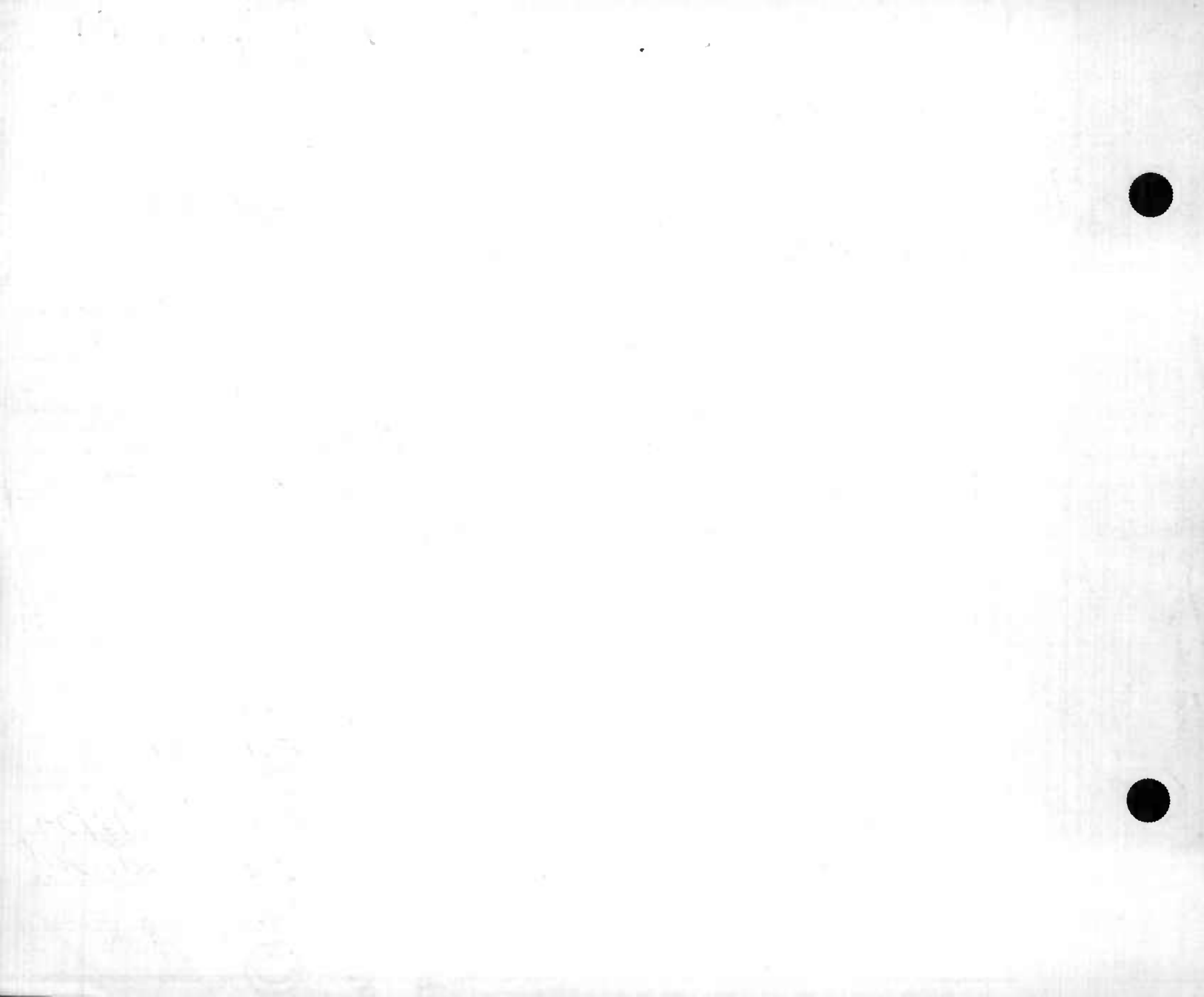
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1. STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MONTGOMERY MIDDLE LAST WEST					2a. DATE OF DEATH MONTH DAY YEAR 8/9/79			2b. HOUR 7:30 P.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR March 27, 1879		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wicomico Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Wicomico 13c. CITY OR TOWN Salisbury					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 213 Holland Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST William J. Phipps					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Jones				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT (daughter) ADDRESS Mrs. Amy Cline, Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 436- DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) AK Amputation of Rt leg APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-10 1976 to 8-9 1979, that (I) (we) last saw the deceased alive on 8-8 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>A.C. Mitchell</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/13/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. Mitchell				22e. ADDRESS POB 2378 Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/13/79		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR AUG 15 1979		25b. REGISTRAR'S SIGNATURE <i>Richard M. ...</i>			

BP

DHMH-16 20M  
(VRA 15, 4) 7/78



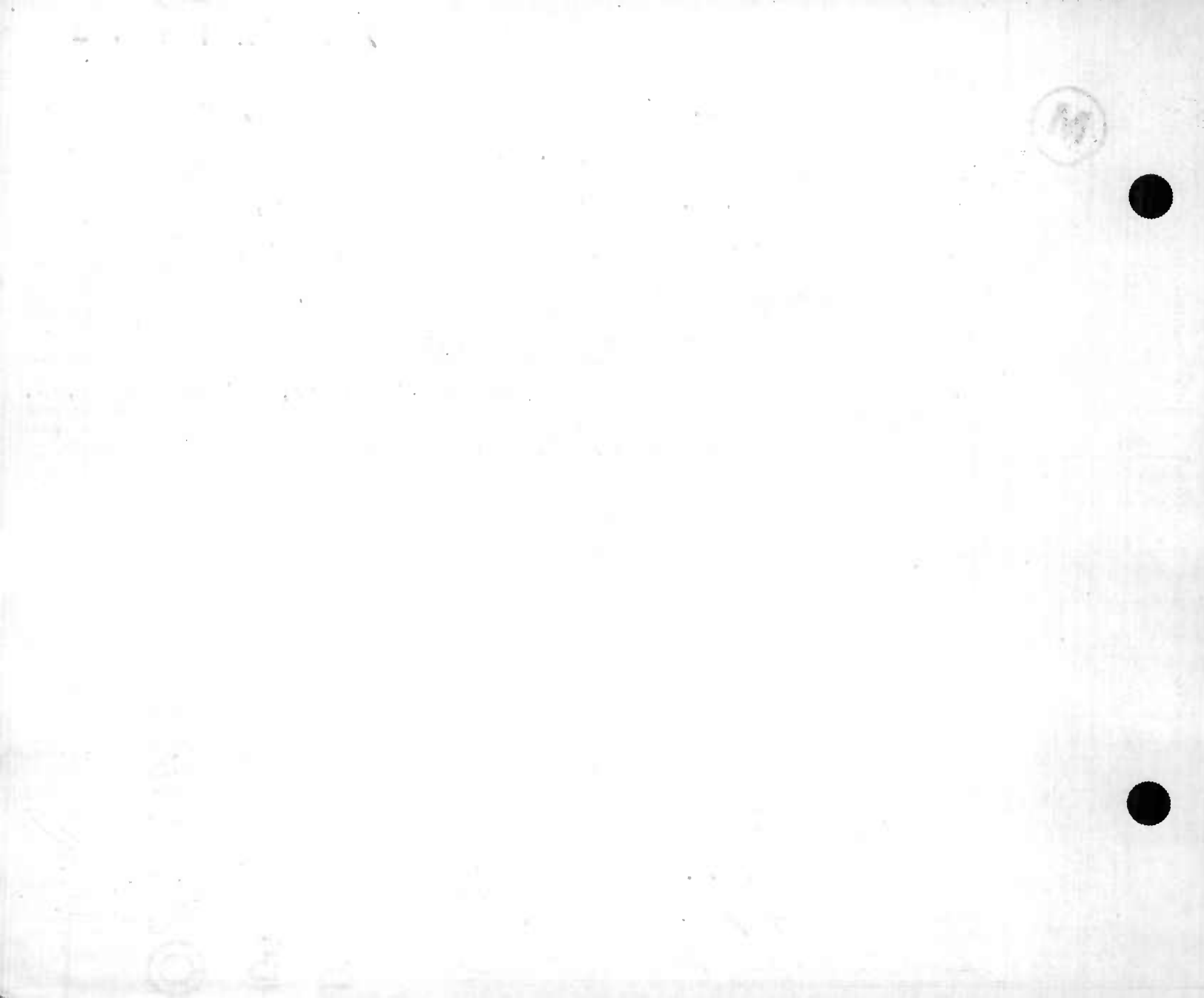
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 9 21142			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
ESTHER L. WIDDOWSON				AUGUST 30, 1979 10:00am			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Sept. 22, 1897		81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Iowa		U. S.				WICOMICO, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
SALISBURY		DEER'S HEAD CENTER		House wife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?			
13b. STATE COUNTY 13c. CITY OR TOWN				13d. STREET ADDRESS			
Maryland Somerset Westover				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> RFD.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
August Leibrand				Regina Wetter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.			
no							
17. INFORMANT ADDRESS				Kenneth Widdowson, Princess Anne, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Adenocarcinoma of colon metastasizing to the liver</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1539							9/29
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/30</u> to <u>8/30</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8/30</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<i>Inja Joe Hwang</i>						8/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Inja Joe Hwang, M.D.				Deer's Head Center, Salisbury, Md. 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF MEDICAL EXAMINER (TYPE OR PRINT)		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		9/21/79		<i>Barbara</i>		<i>Princess Anne, Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
<i>James L. Hannon</i> <i>Princess Anne</i>				SEP 4 1979 <i>Malcolm M. Brady</i>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 21143		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR			
1 DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
Willard Joseph Woodrow Willard		Male		White		Aug. 6, 1901		77 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
New York		USA				Wicomico			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital		Retired Plumber		Plumbing			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		521 Alabama Ave.	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS	
(unknown)		(unknown)		Yes		1920-1924		Mrs. Thelma C. Willard (wife) same as 13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		18b SOCIAL SECURITY NO		17 INFORMANT ADDRESS		18c		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>		1217-01-8100		Mrs. Thelma C. Willard (wife) same as 13				Hrs.	
4140									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
<u>Hypertension, myocardial infarction, COPD, Generalized arteriosclerosis</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>7.24.79</u> , 19 <u>79</u> , to <u>8.1.79</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8.1.79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b SIGNATURE		22c DATE SIGNED					
		<u>D SAGGAR MD</u>		<u>8/1/79</u>					
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
<u>D SAGGAR MD</u>		<u>547 Riverside Drive Suite E Salisbury</u>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		8/4/79		Parsons Cemetery		Salisbury, Wicomico, Md.			
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
<u>HOLLOWAY FUNERAL HOME, Salisbury, Maryland</u>				<u>AUGO 6 1979</u>		<u>Holloway</u>			

BP

1000000

Peninsula General Hospital

Salisbury



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
REG. NO. 79 21144									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary Elizabeth Windsor</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>August 1 1979</i>				
3 SEX <i>FEMALE</i>					4 RACE <i>WH ITE</i>				
5 DATE OF BIRTH MONTH DAY YEAR <i>SEPT. 2, 1901</i>					6 AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>					7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9 BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD.				
10 CITY OR TOWN OF DEATH <i>Salisbury</i>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>				
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>RETIRED</i>					12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>MD.</i>					13b COUNTY <i>SOMERSET</i>				
13c CITY OR TOWN <i>PRINCESS ANNE</i>					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
14 FATHER'S NAME FIRST MIDDLE LAST <i>JAME A. HOLLAND</i>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY E. CLUFF</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>					16b SOCIAL SECURITY NO. <i>213-01-5540</i>				
17 INFORMANT ADDRESS <i>MRS CARLOS BOZMAN PRINCESS ANNE, MD.</i>									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart - Pericardial Failure</i> 4240 DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Long Corrupt Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>Myocardial Vascular Disease</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <i>Alcohol Intoxication</i>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>8/1</i> 19 <i>79</i> to <i>8/11</i> 19 <i>79</i> that (I) (we) lost the deceased alive on <i>8/11</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b SIGNATURE <i>[Signature]</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN G GREEN</i>					22e ADDRESS <i>215 OHIO AVE SALISBURY, MD.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>8/3/79</i>			23c. NAME OF CEMETERY OR CREMATORY <i>ORIOLE CEMETERY</i>			
23d. LOCATION CITY OR TOWN COUNTY STATE <i>ORIOLE, MARYLAND</i>			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
24 FUNERAL DIRECTOR NAME ADDRESS <i>LEVIN R. WILSON PRINCESS ANNE, MD.</i>									

77

1001

1001

x

1001

1001

1001

1001

1001